Susan Pauna, M.S., LCPC

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

______________________________	____________________	________________________
(Name of Patient)	(Date of Birth)	(Social Security Number)

I hereby freely and voluntarily authorize Susan Pauna, M.S., LCPC to release or obtain information to/from:

____

____.

The dates of service to be released/obtained:____

The purpose of this release is _ Coordination of Care _______________________________________ ___________

By checking the spaces below, I specifically authorize the release or disclosure of the following information or records, if such information or records exist:

____Discharge Summary	____Psychological Test Report	____Entire Record
____Neuropsychological Testing Report	____Treatment Plan	____Verbal Communication
____Psychiatric Evaluation/Assessment	____Educational Evaluation	____Billing Information
____Laboratory Reports	____Progress Notes	____Appointment Information
____Medication Records	____Physician Orders	____Other________________

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, but it could affect the effectiveness of treatment. I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Susan Pauna, M.S., LCPC. The revocation shall be signed by me and be witnessed by a person who can attest to my identity. Any revocation will take effect when Susan Pauna, M.S., LCPC receives the revocation, except to the extent that Susan Pauna, M.S., LCPC has already relied on the authorization.

I understand I have the right to inspect or copy any information to be used or disclosed under this authorization. I understand that no person or agency to whom any information is disclosed may re-disclose the information unless I specifically consent to re-disclosure.

Unless otherwise revoked, this authorization will terminate on _____________ or one year from date it was signed, whichever is sooner.

Signature: ____ Date: ________________________________
Patient

Signature: ____ Date: ________________________________
(Parent/Guardian AND Child if ages 12 through 17;
Parent/Guardian ONLY if Child under 12 years of age)

Witness: ____ Date: ________________________________