Tina Schneider, Ph.D.
6264 S. Sunbury Blvd. Westerville, OH 43081
PHONE: 614-653-5281 FAX: 614-675-4449
T.Schneider.PhD@gmail.com

Request Authorization to Release Confidential Records and Information (Adults)

I hereby authorize the following Person or Facility:

_____

Address: _____

_____Phone: _____

_____ To release information to Tina Schneider, Ph.D. _____ To receive information from Tina Schneider, Ph.D

Regarding _____, Born on _____

for the following purposes:

____ Mental health evaluation, treatment planning, care

____ Other _____

These records concern the time between _____ and _____.

In the boxes below, the information to be disclosed is marked by an X.

_____ Intake and discharge summaries _____ Medical history and evaluations

_____ Mental health evaluations _____ Developmental and/or social history

_____ Progress notes, and treatment summary _____ Testing results

_____ Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ____ do not release HIV-related information

____ do not release drug and alcohol information

I have had explained to me and fully understand this request-authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

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Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and State law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

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_____

Signature of Client or Client Representative Printed Name Date

_____

Signature of Witness Printed Name Date