TREASURE VALLEY
PSYCHOLOGY, PLLC

671 E Riverpark Ln, Ste 220
Boise, ID 83706-6559
TEL: (208)344-2071
FAX: (208)344-2075

*Rachel Root, PhD
*Jacob Atkinson, PsyD
*Michelle Cullinan, PMHNP-BC
*Heather Hoyt, PhD
*Anita Elderkin, PhD

Authorization To RELEASE OF INFORMATION

I, ________________________________, hereby give permission to Treasure Valley Psychology providers and staff to **disclose/obtain** the below specified information regarding myself (or ____**):**

CHILD UNDER 14 YEARS OLD / OTHER DEPENDENT

___ENTIRE RECORD
___OTHER ITEM: ____

(Specify Item)

TO/FROM: ____

Name of person to disclose to/from

____
Street Address

____
Telephone Number

____
City, State and Zip

____
Fax Number

The purpose of this release:

___Further mental health treatment/evaluation/care.
___Rehabilitation program services.
___Treatment planning
___Other: ______________________________

I understand that my health information to be released MAY include information related to human immunodeficiency virus (HIV), sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), drug/alcohol abuse, and/or behavioral or mental health services. INITIALS:_______

I understand: I may revoke this consent at any time in writing; I have the right to receive a copy of this authorization form; I understand that upon my written request, you must provide to me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.

This release is effective the date it is signed,
It will expire in 12 months from the signed date; or on: ___________________.

I have read, understand and agree to the terms and information provided above. I acknowledge that I am the client or the legal representative of the client, and I agree that my drawn, typed, or generated signature is a legally binding equivalent to my handwritten signature.

E-sign
or sign: ____
Signature of patient or authorized representative

____
Date

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any alcohol or drug abuse patient.
09/17/2019