

Richard B. King, Ph.D.

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AUTHORIZATION TO RELEASE PATIENT RECORDS

I, the undersigned, hereby request and authorize information and records, as described below, to be released
[to / from]:

Person/Organization Releasing or Receiving Information

[to / from]:

Richard B. King, Ph.D.

I understand that the medical records and information to be released may contain information pertaining to mental health, drug and/or alcohol related treatment, personal and family information, and delinquent and/or adult criminal history. Additionally, results from psychological and neuropsychological testing may also be released. It may also contain related medical information, including test results from medical laboratories.

The disclosure of records and information authorized herein is required for the purpose of treatment and/or completing a comprehensive evaluation.

I specifically request that the following records be released:

- | | |
|---|---|
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Mental Health Evaluation | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Medication Administration Records |
| <input type="checkbox"/> Psychological Testing Results | <input type="checkbox"/> School Records (Grades, State tests, etc.) |
| <input type="checkbox"/> Neuropsychological Testing Results | <input type="checkbox"/> Confidential School Records (IEP's, etc.) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology and EEG Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Alcohol/Drug Abuse Treatment |
| <input type="checkbox"/> HIV Related Diagnosis/Treatment | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> All of the Above |

This authorization is subject to revocation by the undersigned at any time except to the extent that action based on my authorization has already been taken. I understand that revocation must be in writing. A copy of this authorization/request is to be as valid as the original.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This authorization/consent is given freely and I have not been threatened with discontinuance or refusal of service if I do not sign this form.

I agree that above persons/organizations may Fax the above records.

Name of Patient

Patient's Birth Date

Social Security Number

Patient's Signature (If Adult)

Date Signed

Guardian/Legally Authorized Representative of Patient

Date Signed