

TheITMGroup

INTENSIVE TREATMENT MODALITIES

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Jennifer Sager, Ph.D.

AUTHORIZATION TO RELEASE INFORMATION

I voluntarily authorize, **Jennifer Sager, Ph.D.**, to:

Obtain from _____ Release to _____ Exchange with _____ (please initial an option)

_____ NAME OF PERSON

_____ NAME OF FACILITY

_____ ADDRESS

_____ CITY, STATE, ZIP

TELEPHONE# _____

Written and / or verbal information from the medical record / practitioner of:

Name of Patient _____ Date of Birth _____

This information is to be used for the purpose of:

(Check those that apply)

- School placement
- Follow-up Care
- Outpatient treatment
- Insurance determinations
- Referral for services
- Academic Progress
- Other (Specify) _____

Specific information to be released:

(Check those that apply)

- Psychiatric Discharge Summary
- Psychiatric Admission Summary
- Psychological Evaluation
- Master Treatment Plan
- History and Physical Examination
- Letter to Referral Source
- School Records / Information
- Outpatient Treatment Summary
- Other (Specify) _____

These records may include confidential psychiatric, psychological, drug, alcohol and / or medical information. Treatment is not conditional upon authorization to release information. To understand your privacy rights more fully please refer to our "Notice of Privacy Practices". This authorization expires ninety (90) days from the date of signature or from the date of termination of services, whichever is later, unless otherwise revoked by me in writing prior to that time.

Jennifer Sager, Ph.D., is not to be held liable for any release of information made prior to receiving such notification.

Signature of patient

Signature of parent / legal guardian

Witness Signature

Witness Signature

Date

Date