Daniel B. Goldman, Ph.D., LLC
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AUTHORIZATION TO RELEASE AND OBTAIN CONFIDENTIAL INFORMATION

Patient Name:		DOB:	
Address:	City:	St:	Zip:
Phone:	Alternate Phone:		

I hereby authorize Daniel B Goldman, PhD, LLC, to ☐ release and obtain ☐ release only ☐ obtain only information, notes, and records to/from:

Name: _____

Address: _____

Phone: _____ Fax: _____

I hereby give permission to allow the release of the following information/documents from my treatment record to the above-named person/entity:

☐ **All Mental Health Notes/Information** ☐ Treatment Summary ☐ Psychological Test Results

☐ Dates of Treatment/Service ☐ Initial Intake / History ☐ Psychotherapy Notes

☐ Medical/Psychological Diagnoses ☐ Billing Records ☐ Verbal Communication

☐ Other (specify) _____

For the purpose of (*optional*): _____

I authorize Daniel Goldman, Ph.D., to furnish information, including copies of my protected health information and other treatment records to the above-named person, organization, or its agents. If noted, I specifically authorize Dr. Goldman to release psychotherapist notes for the purposes set forth in this authorization form. I further agree to indemnify and hold harmless Daniel B Goldman, PhD, LLC, and Daniel Goldman, Ph.D., from all liability that may arise from the release of the information herein requested. I understand that the protected health information (PHI) released may contain alcohol, drug, HIV/AIDS information, and psychological/psychiatric information. I authorize the disclosure of the protected health (PHI) as stated.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but doing so will not have any effect on actions taken prior to the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it. However, I may be refused access to certain notes, reports, raw testing data, or information compiled.
6. I may receive a copy of this form after I sign it.
7. Without written revocation, this consent will automatically expire one (1) year from the date signed.

_____ _____

Signature of Patient / Patient's Representative Date

_____ _____

Print Name of Patient / Patient's Representative If patient's representative, describe relationship

Witnessed by _____ *on* _____.

Name & Title *Date*