# CHRIS KAEPPNER, PH.D.

**Licensed Psychologist**

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**Authorization for Retrieval and Disclosure of Health Information and Records**

NAME OF PATIENT: _____ DOB: _____

Person or Facility: _____

Address: _____

Phone: _____ Fax: _____

[ ] I hereby authorize the above named-person or facility to release to Dr. Chris Kaeppner records about the above-named patient, concerning the time between _____ and _____.

The information to be disclosed is marked by an x in the boxes below, and the items not to be released have a line drawn through them.

____ Intake and discharge summaries
____ Mental health evaluations
____ Educational records
____ Other: _____
_____ Medical history and evaluations
_____ Developmental and/or social history
_____ Progress notes, and treatment or closing summary

[ ] I hereby authorize Dr. Chris Kaeppner to disclose information regarding the above-named patient's mental health treatment to the above-named person or facility. The following information will be disclosed:

Diagnosis, progress in therapy, further intervention needed, prognosis, _____

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

[ ] I hereby refuse to give authorization for release of any 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 consequences and implications of their release. I understand that this authorization is effective immediately and will remain in effect for as long as Dr. Kaeppner is providing mental health services. I understand that I have the right to revoke this authorization, except if the authorization was obtained as a condition of obtaining insurance coverage, or to the extent that action based on this consent has already been taken. Such revocation must be submitted to the Dr. Kaeppner in writing.

I understand that I may refuse to sign this authorization and that Dr. Kaeppner may not condition my treatment upon whether I do so. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected. I understand that I have a right to inspect or copy the protected health information to be used or disclosed.

I have read and understand this information, and am the client or am authorized to act on behalf of this client.

_____ _____ _____

Patient or Parent/Guardian Signature | Relationship | Date