SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

Authorization for Release of Information

Client Name: _____ Date of Birth: _____

I hereby authorize: To:

Spectrum Psychological and NeuroTherapy, P.C. _____Release Information To
3145 Virginia Beach Blvd. Suite 100
Virginia Beach, VA 23452 _____ Obtain Information From
Phone: 757-640-1882
Fax: 757-640-0253

Name/Agency: _____
Address: _____
Phone: _____Fax: _____
For the purpose of: Treatment Planning
Specific Information to be released: Service dates of: _____to_____
_____ Psychiatric Evaluation
_____Oral Communication
_____Psychological Testing/Assessment
_____Progress/Psychotherapy Notes/Labs
_____School Records
_____Other (specify) _____

This authorization may be relied upon when transmitted by FAX ____Yes _____No
I further authorize the information to be sent by FAX ____Yes _____No

1. I understand that this authorization will expire 12 months after the date signed below.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Spectrum Psychological Services in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be disclosed and would no longer be protected by these regulations.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Witness

_____
Name of Clinician