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CONSENT FOR RELEASE OF PROTECTED HEATH CARE INFORMATION

I, _____, hereby authorize
(Print full name)

Timothy Freitas, Psy.D. to exchange, release or obtain private health care information pertinent to my treatment with:

Name: _____

Type of Professional: _____

Agency: _____

Address: _____

Phone(s): _____

I release Dr. Freitas from any legal liability resulting from the release of this information with the understanding that he will exercise reasonable professional standards.

I understand that once protected heath information is disclosed, it may be disclosed by the recipient and may not be protected by federal privacy laws or regulations. In addition, I understand that as a part of the treatment of the identified patient, family history information may be released.

I understand that this consent may be revoked by the patient at any time except to the extent that the disclosure has already been made in reliance on the previously given authorization. To revoke this authorization, send written notification to this office.

This form has been fully explained and I certify that I understand its contents.

Client's Signature _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Print name: _____

(If applicable)