Teresa B. Olson, Psy.D.
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West Chester, OH 45069

Clinical Psychologist
Certified Clinical Hypnotherapist

(513) 860-3156
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TWO WAY AUTHORIZATION TO RELEASE INFORMATION

I authorize Teresa B. Olson, Psy.D. and _____
(Name of professional/agency)

Mailing address/phone: _____

to release to/exchange with each other the following information from _____

(my/my child's) confidential record regarding treatment:

__ Diagnosis __ Psychological Evaluation __ Discharge Summary

__ Treatment/Progress Notes __ Treatment Plan __ Initial Assessment

__ School Functioning __ Medication

__ Other: _____

This authorization includes release of information concerning AIDS/HIV related conditions and testing, substance abuse, and psychiatric/psychological conditions. I understand that release of the above information is for the following purpose(s):_____

and will be limited to the above-specified items. This consent will automatically expire:

__ 90 days after the date signed below
__ 180 days after the date signed below
__ the date of discharge from treatment with Teresa B. Olson, Psy.D.

unless otherwise revoked by me in writing.

Your revocation will not be effective to the extent that I, Teresa B. Olson, Psy.D., have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

RELEASE DISCLOSURE OF THIS INFORMATION TO ANYONE IS PROHIBITED. Federal Reg. 42 USC 4582, CFR, pt. 2 may protect this information. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I acknowledge that I have read and fully understand this authorization.

_____ _____
(Signature of person authorizing) (Date)

_____ _____
(Relationship to client) (Client's Date of Birth)

_____ _____
(Signature of Witness) (Client SSN)