SOUTHEASTERN
PSYCHOLOGICAL ASSOCIATES

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Release start date: _____ Release expiration date: _____

Client Name: _____

Date of Birth: _____

Social Security Number: _____

I, _____, hereby authorize Southeastern Psychological Associates, Inc. (SEPA) to release ☐ and/or receive ☐ (check all applicable options) information contained in client records from the individual or organization listed below:

CHECK ONLY ONE OPTION BELOW

Physician ☐ Please list physician name, phone and fax in the space provided below.

School ☐ Please list school name, phone and fax in the space provided below.

Other ☐ Please list entity name, phone and fax in the space provided below.

Name: _____

Phone: _____

Fax: _____

Information to be disclosed: (check all applicable options)

Social history ☐ Medical history ☐ Progress notes ☐ Psychological evaluation ☐

Treatment progress ☐ Discharge summary ☐ All of the above ☐

Purpose for disclosure: (check all applicable options)

Ongoing care/treatment ☐ Assessment/Evaluation ☐ Collaboration of Care ☐

This release will be valid for one year from the date of signature below unless otherwise indicated and may be revoked, in writing, by the client at any time. Revoked on _____. See attached.

_____

Client or Legal Guardian Signature Printed Name Date

_____

SEPA Staff Signature Printed Name Date