WASHINGTON · UNIVERSITY · IN · ST · LOUIS

Psychological Service Center
Department of Psychological & Brain Sciences
314-935-6555

Authorization for the Use or Disclosure of Protected Health Information

(Authorization for Release of Information)

I, ___________________________authorize The Psychological Service Center at Washington University to:

____ Release Information To:
____ Receive Information From:

Regarding ____ Myself
____ My Dependent Named:____

Purpose of Disclosure: ____ Psychological Treatment
____ Neuropsychological Assessment
____ Other: ____

Information to be Disclosed:

___ Intake Report
___ Termination Summary
___ Neuropsychological report with summary of scores
___ Neuropsychological report without summary of scores
___ Verbal communication only **(no records will be released)**
___ Other:____

Secondary release of information in the file from other sources not named in this authorization is
____ Permitted
____ Prohibited

This authorization may be revoked by a written request to The Psychological Service Center at Washington University at any time except to the extent that action has already been taken in reliance on it. If not previously revoked, this authorization will terminate upon: (insert date or event triggering expiration)

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I understand the nature and purpose of the authorization, and I had the opportunity to ask questions about it. I understand that I may refuse to sign this authorization. I understand that the information to be released may be subject to re-disclosure by the recipient (s) and may no longer be protected by the privacy regulations.

Printed Name:____________________________________

Signature____ Date:___________________________________

____ ____
Relationship to Individual Client's Social Security Number or Birth Date