

# Ada Liberant, Psy.D.

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## RELEASE OF INFORMATION FOR MINORS

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Authorized Patient Representative: \_\_\_\_\_

On behalf of the patient, for whom I am a legal guardian of, I authorize Ada Liberant, Psy.D., whose offices are located at the address at the bottom of this page, to disclose and/or obtain treatment information from the following physician, psychiatrist, teacher, or any other person I choose to name below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

If you agree to the **release of all of** your Protected Health Information (PHI), then check the first option below:

\_\_\_\_\_ All Protected Health Information (PHI) (e.g., Patient's complete psychiatric record)

If you want to **limit** what protected health information is released, then check off all the option(s) that you agree to below:

\_\_\_\_\_ Mental Health Diagnosis

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ Treatment Plan

\_\_\_\_\_ Medication Records

\_\_\_\_\_ Discharge Summary

\_\_\_\_\_ Neuropsychological Assessment or Academic Testing Results

\_\_\_\_\_ Substance Abuse Information (Including Assessment & Treatment Records)

By signing below I acknowledge that the above information about the patient in my legal guardianship may be released, discussed, or disclosed. I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to the office of Ada Liberant, Psy.D. Unless otherwise revoked, this consent expires in 12 months from the date signed. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may redisclose the information and it might not be protected by federal or state privacy regulations.

Signature of Authorized Patient Representative: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_