Eric L. Hartman, PsyD
Licensed Psychologist
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CONSENT TO RELEASE / EXCHANGE INFORMATION

I, _____, authorize Eric L. Hartman, PsyD. to:

Release_____ *(Please initial)* **Obtain/Exchange**_____ *(Please initial)*

confidential mental health information to /from/with:

Name/Agency: _____

Phone/Fax: _____

For my child or adolescent _____ Date of Birth: _____

Information to be shared for what purpose: _____

Content of information to be shared:
_____Psychological records/information (e.g., reports from psychological testing, assessment/treatment summaries, developmental history, course of treatment, discharge summary, session notes)
_____Educational records – academic and behavioral – to include completion of ratings scales
_____Medical and medication information
_____Family and social information
_____Substance use or abuse information
_____Legal information
_____HIV / AIDS information

I understand that the shared information is intended to be used for specific purposes related to psychological services for my child / adolescent. Those purposes can include determination of insurance benefits, support for the development of appropriate treatment goals, coordination of services between service providers, and/or advocacy on behalf of my child / adolescent.

I understand that Dr. Hartman may not condition my child's / adolescent's psychological treatment on my refusal to sign this authorization. Signing this form indicates authorization for this information to be exchanged or released by phone, the US Postal Service, fax, or e-mail. This authorization is in effect for one year from the date signed.

I may revoke this request at any time. I release Dr. Hartman and his staff from any liability connected with the use of these records, or the information in them, by anyone outside of Dr. Hartman's office. I understand that I have the right to seek assurances from the persons/organizations authorized to receive the information that they will not redisclose this information to any other party without my further authorization.

This authorization is fully understood and is made voluntarily on my part, on behalf of my child / adolescent.

_____	_____	_____
Signature of Responsibility Party	Relationship to Client	Date