Consent to Release Confidential Information to Another (third) Party

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1. I, _____ (print your name and date of birth), am completing this form to allow the use and sharing of my protected health information.

2. I authorize Anna B Baranowsky, Ph.D., C. Psych. to disclose my records (which may include admission and discharge summaries, psychological evaluations, reports, assessments, treatment notes, progress notes, psychotherapy attendance records).

3. Dates of care for which the information will be disclosed include:

   From *beginning of this treatment episode* to *present time*
   Or specify the time period for which you are giving Dr. Baranowsky the permission to release your records:
   From _____ to _____ and

4. I authorize Dr. Anna Baranowsky to disclose the above noted information to this person &/or organization (list below the person(s) and/or organization(s) receiving records from Dr. Baranowsky. Provide address and contact info:

   _____

   _____

   Street:_____City:_____Postal Code:_____
   Phone:_____Fax (if known):_____

5. I understand and agree that Authorization will remain valid unless specified:

   _____

   [Note a date or event upon which this Authorization expires.]

6. I understand that I can revoke or cancel this authorization at any time by sending a letter to Dr. Baranowsky. This will prevent future disclosures.

   _____ _____
   Signature of client or his or her personal representative Date

7. I, Anna B Baranowsky, Ph.D., C. Psych. have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

   _____ _____ _____
   Signature of professional Printed name of professional Date