HUFFMAN PSYCHOLOGY, PLLC
Jennifer L. Huffman, Ph.D., ABPP-CN and Associates
Clinical Psychology and Neuropsychology Services

Request/Authorization for Release of Information

Client Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Birthdate: _____

I hereby authorize and request that the following persons/agencies:
Name: _____
of _____
Address: _____
City, State, Zip Code: _____
Telephone Number with Area Code: _____

- ☐ **Obtain** information contained in my clinical records **from** Huffman Psychology, PLLC
- ☐ **Release** information contained in my clinical records **to** Huffman Psychology, PLLC

for the purpose of:

- ☐ Assist with treatment planning or evaluation
- ☐ Client request
- ☐ Other: _____

The information to be released: ☐ **ALL OF BELOW**

☐ History and physical	☐ MRI, CT, EEG, X-ray, SPECT, PET and evoked potential studies
☐ Discharge summary	☐ Inpatient or outpatient treatment records
☐ Consultations	☐ Psychological/psychiatric history and/or evaluation(s)
☐ Emergency room report	☐ Neuropsychological scores, data, or summaries
☐ Financial information	☐ Neuropsychological test report

☐ Academic or educational records including achievement and other tests' results

☐ Other: _____

This consent may be canceled (revoked) in writing at any time to the extent that the health care provider(s) named above or custodian of the records has not already taken action in the reliance upon it. This information is disclosed in accordance with Federal confidentiality rules (42 CFR, Part 2), Sections 748, 750, and 784 of Michigan Public Act 258, 1974 and Michigan Public Act 174, 1989. This authorization will expire on _____ (or 60 days from the date signed if left blank).

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I have read the above and acknowledge that I understand the terms and conditions of this authorization.

Signature of client	Printed name		Date
Signature of parent guardian/representative	Printed name	Relationship	Date

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