Ohio Board of Psychology

INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION
GENERAL RELEASE

I,_______________________________(***name of client, guardian, or parent***), hereby authorize and instruct ________________________________(***name of psychologist, school psychologist, or behavior analyst***) to release and furnish to the Ohio Board of Psychology, its agents and/or legal representatives any and all information related to his or her treatment or evaluation including, but not limited to: all psychological records, diagnoses, prognosis, treatment plans, psychological test reports and raw test data, written statements and/or reports, billing records, and any documentation describing treatment or evaluative services. I further authorize the above referenced license holder to fully cooperate with the Board's investigation by rendering testimony, participating in interviews or otherwise, verbally or in writing, and discussing the services rendered to:

Name of client(s) or patient(s): ____

Relationship (circle all that apply): ***Self/undersigned*** ***Child/ren*** ***Other***

I understand that I may revoke this authorization in writing at any time. Unless revoked in writing, I understand that this authorization is valid for one (1) year from the date of the signature indicated below:

Full Name of Individual Authoring Release: ____

Current Address:____

Home phone:__________________________ Cell Phone:_____________________________

Email address:____

Signature:______________________________________ **Date**:________________________

Ohio Board of Psychology

INFORMED CONSENT TO RELEASE CONFIDENTIAL INFORMATION
PSYCHOTHERAPY NOTES (HIPAA)

I, ________________________(***name of client, guardian, or parent***), hereby authorize and instruct___________________________(***name of psychologist, school psychologist, or behavior analyst***) to release and furnish to the Ohio Board of Psychology, its agents and/or its legal representatives any and all information in my record or file, specifically psychotherapy notes as defined in the HIPAA federal guidelines, for services rendered to:

Name of client(s) or patient(s): ____

Relationship (circle all that apply): ***Self/undersigned*** ***Child/ren*** ***Other***

I understand that I may revoke this authorization in writing at any time. Unless revoked in writing, I understand that this authorization is valid for one (1) year from the date of the signature indicated below:

Full Name of Individual Authoring Release: ____

Current Address:____

Home phone:__________________________ Cell Phone:_____________________________

Email address:____

Signature:______________________________________ **Date**:______________________