Karen Toth, PhD, Child Psychology, PLLC
2150 N 107th St, Suite 504 ▪ Seattle, WA 98133 ▪ 360.220.6040 v ▪ 206.362.2323 f

Authorization to Release Confidential Records and Information

A. CHILD/PATIENT IDENTIFYING INFORMATION
Name: ____________________
Address: ____________________
Parent Phone: ____________________ Birth date: ____________
Parent/guardian name: ____________________
____

B. I HEREBY REQUEST KAREN TOTH, PhD, CHILD PSYCHOLOGY, PLLC TO (check all that apply):

- ❑ Release information to:
- ❑ Gather information from:

Name/address of person, provider, agency, or facility: ____________________
____

Phone: ____________________ Fax: ____________________ Email: ____________________

C. THIS INFORMATION MAY CONTAIN THE FOLLOWING (CHECK ALL THAT APPLY):

- ❑ Psychological test results/reports and questionnaires
- ❑ Psychiatric evaluation reports
- ❑ Treatment plans and therapy notes
- ❑ Summary of previous mental health treatment
- ❑ Social history information including family, education, and employment details
- ❑ Medical information
- ❑ School records/discuss student by phone re: school functioning
- ❑ Other: ____________________

D. This authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

E. This authorization is valid during the pendency of any claim or demand made by or on behalf of me/the patient. I understand that I may void this authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this authorization, it will automatically expire **one year** from the date I signed it, or upon the following expiration date or event: ____________________.

F. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

G. I affirm that everything in this form that was not clear to me has been explained.

____
Signature of Patient (13 years and older) | Printed Name | Date

____
Signature of Parent/Guardian | Printed Name and Relationship | Date