Valley
Psychological Associates
1045 S. Cedar Crest Boulevard
Allentown, Pa 18103-5443

AUTHORIZATION TO RELEASE/REQUEST INFORMATION

Patient Name: _____ Date of Birth: _____
Address: (Including Zip Code)_____
Telephone Number: (Including Area Code) _____

☐ I authorize Valley Psychological Associates to **release** the above individual's mental health information to:

Name:_____
Address:_____
Phone No: _____ Fax No:_____

☐ I authorize Valley Psychological Associates to **request** the above individual's mental/medical health information from (if same individual/agency as above, write "same as above"):

Name:_____
Address:_____
Phone No: _____ Fax No:_____

The information to be released/requested is:

☐ Psychological/psychiatric Evaluation
☐ Progress Notes
☐ Psychological/Vocational Testing
☐ Treatment Summary
☐ Other _____
☐ Complete medical record

The information is for the purpose of: _____
I understand that I have no obligation whatsoever to disclose information from my client record.

If there is any information I **do not want released/requested**, I have indicated this specifically below:

_____
_____

I understand that my authorization shall remain in effect for a period of one year from the date of my signature and that all information released will be handled confidentially, in compliance with Federal and State Laws.

I also understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to Valley Psychological Associates. I understand that, if requested, Valley Psychological Associates will permit me to review the information to be released.

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date