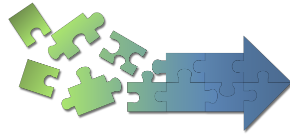

Forward Thinking Assessment

Comprehensive ● Individualized ● Collaborative

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ______________________________________ Date of Birth:______________

I authorize Jennifer Nail, Ph.D., and/or Caitlin B. Dunning, Psy.D., of Forward Thinking Assessment LLC to release information regarding the above-referenced individual to:

____ ___________________________
Name of person Phone

____ ___________________________
Name of organization Fax

____
Street Address

____
City State Zip Code

The following information is requested to be released:

[ ] Psychological evaluation [ ] Intake summary

[ ] Discharge/treatment summary

[ ] Other: ____

I authorize [ ] Written communication [ ] Verbal communication

This authorization will remain in effect until ____________________________________.

I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that action has already been taken. I understand that I may request a copy of this form after I sign it and that I may inspect and/or request a copy of the information I have authorized for disclosure. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

____ __________________
Signature of responsible party Date

____ __________________
Printed name of responsible party Relationship to patient