Sally R. Brinza, PhD, LP, LLC
Licensed Psychologist

Email drbrinza@protonmail.com
Phone (612) 978-5058

www.sallybrinza.com

AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

This will authorize Sally R. Brinza, PhD, LP, LLC to both release to, and obtain from:

______________________________ ______________________________
(Name of Provider) (Address)

____
(City/state/zip) (Phone) (Fax)

THE FOLLOWING INFORMATION; Applicable dates:__________________

Medical Records _________
School Records _________
Psychological Testing _________
Reports of Therapy _________
General Communication _________ Other _________________________________

The purpose of this information is for assessment and treatment planning. This authorization for release and exchange is valid for one year from the signature date.

FROM THE RECORDS OF:

____
(Name of client) (Address)

______________________________ ______________ ____________________
(City/state/zip) (Date of Birth) (Phone number)

I understand that I have the right to inspect and copy the information disclosed. I may cancel this authorization in writing at any time. Stopping this authorization will not apply to information that has already been released or disclosed. This authorization shall expire without my express revocation one year from the date provided below. Any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules. My psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

____ ________________________
(Signature of client or parent/legal guardian) Date