North Star Therapy, PLLC
Arezoo Khanzadeh, Psy.D. LCP
3516 Plank Road, Suite 6C
Fredericksburg, VA 22407
P: 540- 388-2891 F: 540-412-0223

Patient Name:_____ Patient Date of Birth: _____

Release of Information

I, _____(Patient) , hereby authorize North Star Therapy, PLLC and _____(name) , at_____(telephone) to exchange information.

The type of information to be disclosed:

_____ DSS/CPS Records
_____ Medical/hospital records
_____ Mental Health Diagnostic/Evaluations
_____ Treatment plan
_____ Educational & School records/IEP
_____ Psychotherapy notes (if applicable)
_____ Substance abuse eval/treatment
_____Other: _____

The purpose of such disclosure:

_____ Ongoing treatment
_____ Parental/custody evaluation
_____ Transfer
_____ Coordination of care
_____ Substance Abuse History
_____ Other: _____
_____ Consultation
_____ Psychological evaluation
_____ Legal issues
_____ Health benefit utilization
_____ Insurance/billing

Date of records requesting: _____

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. North Star Therapy, PLLC and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released. This consent is in effect until_____(date).

I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a Patient during therapy sessions is legally confidential in the case of licensed clinical psychologist, with exceptions. These exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations. The recipient may otherwise be prohibited under federal law from redisclosing substance abuse information, AIDS/HIV status, or mental health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

NOTE WHERE INFORMATION ACCOMPANIES THIS RELEASE FORM: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug using Patients.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____
Patient or Guardian Signature & Date Arezoo Khanzadeh, Psy.D. & Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

Revised November 2022