North Star Therapy, PLLC
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# Release of Information

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

The type of information to be disclosed:

_____ Evaluations
_____ Medical/hospital records
_____ Diagnostic
_____ Psychological/medical testing
_____ Course of treatment letter
_____ Psychotherapy notes (if applicable)
_____ Discharge summary letter
_____ Treatment plan

The purpose of such disclosure:

_____ Ongoing treatment
_____ Medical care
_____ Transfer
_____ Coordination of care
_____ Other: _____
_____ Consultation
_____ Evaluation
_____ Legal issues
_____ Health benefit utilization
_____ Insurance/billing

Exceptions: _____

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 take 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 client 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.

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.

_____ _____

Client's Signature/ Date Arezoo Khanzadeh, Psy.D. / Date

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