MALIKA KAPADIA, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
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(585) 210-8488

Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

Email: _____ **Phone Number:** _____

I authorize my therapist to communicate with the following individuals or agencies regarding general concerns about my past, present, or future physical or emotional state, treatment given, and billing information. I have listed below any specific restrictions on the types of information to be released.

☐ **I authorize Malika Kapadia, Psy.D. to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

AND/OR

☐ **I authorize Malika Kapadia. Psy.D. to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

TYPE OF RECORDS AUTHORIZED: ☐ **Psychiatric/Psychological Evaluation and/orTreatment**
☐ **Drug/Alcohol Evaluation and/orTreatment**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:** _____

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans**

☐ **Treatment Summary** ☐ **Academic Functioning** ☐ **Billing/Financial Information**

☐ **Other:** (please describe) _____
_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**

☐ When the requested information has been sent/received.
☐ 90 days from this date. ☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

☐ When I am no longer receiving services from Malika Kapadia, Psy.D.
☐ One year from this date. ☐ Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Malika Kapadia, Psy.D., except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Client Signature: _____ Date: _____