Authorization to Release Confidential Mental Health Care Information

KELLAND
PSYCHOLOGICAL

Kelland Psychological Services
30 Crossing Lane, Suite 201
Lexington, Virginia 24450
TEL: 540.817.4375

Patient Information:

Name (Last, First, MI):	
DOB (MM/DD/YYYY):	Social Security #:
Address:	Tel#:

☐ **Release Information To:** ☐ **Request Information From:** ☐ **Release & Request Information:**
(Complete Box Below)

Name (Parents, School, MDs/PCPs, Hospital, etc.):		
Street Address:		
City:	State:	Zip Code:
Tel#:	Fax#:	

Information to be Released (Check all that Apply):

☐ Verification/ Participation in Counseling/Psychotherapy
☐ Clinical Summary Letter/Email
☐ Complete Copy of All Records
☐ Verbal Clinical Summary
☐ Assessment/Evaluation Results
☐ Treatment Notes
☐ Other (specify): ____________________

Purpose of Disclosure (Check all that Apply):

☐ Personal ☐ Coordination of Care with other Providers ☐ Academic Accommodations
☐ Consultation with Family ☐ Consultation with Ecclesiastical Leaders ☐ Consultation with Attorney
☐ Other (specify): ____________________

I do hereby authorize and direct Chad J. Kelland, Psy.D. of Kelland Psychological Services to release and furnish confidential mental health information to the above identified individuals or organizations as noted/designated. The information being released shall be limited to the above identified (CHECKED MARKED) information for the purposes endorsed herein. I understand that I am giving my permission to the Chad J. Kelland, Psy.D. or other named third party for disclosure of confidential mental health information. This consent is not a condition of treatment at Kelland Psychological Services. I also understand that this authorization is subject to revocation, but that my revocation is not effective until delivered in writing to Chad J. Kelland, Psy.D. A copy of this consent and a notation concerning the persons or third parties to whom disclosure of confidential mental health information has been authorized shall be included with my clinical records. The person who receives the records or information to which this consent pertains may NOT re-disclose them to another party without my separate written consent unless such recipient is a provider who is permitted to make a disclosure by law. I understand that this authorization expires 12 months (365 days) from the date signed below.

____________________________________ ____________________

Signature of Patient (or parent/guardian if under 18 years old) **Date**

5/11/2018