Psychotherapeutic and Psychological Services
David Holbein Rademacher, MA LPA LPC NCP

This authorization form implements the requirements for client authorization to use and disclose health information protected by federal health privacy law (45 C.F.R. Parts 160, 164); the federal drug and alcohol confidentiality law (42 C.F.R. Part 2), and the state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

Consent for Release of Information:

Patient Name: ______________________________________DOB:________________

Give David Rademacher permission to exchange information with the following:

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And to release/exchange the following information about my treatment:
Dates of Treatment:_______________ ☐ Psychological Assessments/reports
☐ Progress Updates/Verbal ☐ Participation in treatment ☐ Medical treatment

Other: ____

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For the purpose of: ☐ Coordinating care ☐ Insurance ☐ Request of Individual
☐ Legal Representation
Other:____

I understand that this consent for release of information is voluntary, and that I can limit the extent of information I release to anyone listed above. This consent to release information can be revoked or terminated at any time by submitting a written revocation to this office, except for actions already taken based on this release. This consent will expire one year from the date of signature.

I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

I understand that I may inspect or request a copy of information that is used or disclosed under this authorization. I understand that refusal to sign this authorization will not result in denial of treatment.

Signed (client or guardian): ____
Relationship to patient: ________________________
Date: _______________

Witnessed by: ____

Date: ______________

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