**Comprehensive Psychological Assessment Services, PLLC is hereby authorized to:**

**Patient’s name: DOB:**

**Obtain □ Provide □ Exchange with □**

**Name:**

**Address: City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State: Zip code:**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date(s) of service(s) requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

All protected health information regarding:

**Please check ALL that apply**

**□ All □ Verbal/Telephone Information □ Progress Notes □ Medical Records □ Psychological/Neurological Testing Records □ Medication List**

A copy or facsimile of this authorization shall have the same force as the original. This authorization is valid for one year from the date of signature or until:

I understand that my substance use disorder records are protected under federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R.Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent, unless otherwise provided for by the regulations. I will not be denied services if I refuse to consent to a disclosure for other purpose. This Authorization does not extend to HIV test results . [initials]

I have been provided a copy of this form . [initials]

I understand that I can revoke this release at any time, in writing; however, my revocation would not cover action already taken on the basis of this authorization. I further authorize the delivery of this release document to its intended recipient via U.S. Mail or Fax.

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPAS Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_