Fayetteville Psychotherapy Associates, PLC
Psychotherapy for Difficulties in Love, Work, Mood, & Creativity™

William E. Spaine, Psy.D.
(479) 442-8900

AUTHORIZATION FOR DISCLOSURE FOR RELEASE OF INFORMATION (GENERAL CONSENT FORM)

Released to (name): _____ Phone: _____

Address: _____

I, the undersigned, do hereby authorize William E. Spaine, Psy.D., to disclose and receive any protected Medical and Mental Health information, whether written or verbal, including psychological and psychiatric records, of the individual named below to and from the party designated above:

Patient name:_____ Date of birth: _____
(patient printed name)

My consent authorizes the exchange of information between Dr. Spaine and the party above, specifically as it pertains to:

☐ Clinical Impressions ☐ Diagnostic Impressions ☐ Psychosocial Data
☐ Medication Management ☐ Medical Records ☐ Laboratory Records
☐ Other (explain) _____

I understand that if the records requested to be released include information relating to **sexually transmitted disease, AIDS or HIV, alcohol or drug use, or mental health information**, this information may be released pursuant to this authorization.

This authorization will expire on the following date: _____. If no date is specified, this authorization shall expire one (1) year from the date signed below. I understand that I may revoke this authorization at any time by giving written notice to the therapist named above, except that a revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

The therapist listed above and Fayetteville Psychotherapy Associates, PLC are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations.

I agree to pay the copying cost, including other expenses allowed by law, as outlined in the Psychotherapist-Patient Services Agreement.

I understand that my therapist will not condition treatment, payment, enrollment or eligibility for benefits upon the signing of this authorization. I understand that I have the right to refuse to sign this authorization.

Signature of Patient or Legal Representative_____ Date: _____

If Legal Representative, authority of Legal Representative_____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased)

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