Healing Path Psychology, LLC
35 E Elizabeth Ave, Ste 26, Bethlehem, PA 18018
Phone: 610-320-2366

Authorization to Release Confidential Records and Information

A. Identifying information: Name: _____ Date of birth: ___/___/

Current phone(s): _____ Social Security #: _____ Medical record #: _____

Name of parent/guardian (if applicable): _____ Phone #: _____

B. Because I believe it is in my/our best interest, I authorize the release of information described below:

FROM/TO:		**FROM/TO:**
Person or organization:		Person or organization:
Healing Path Psychology and employees		_____
Address: 35 E Elizabeth Ave, Ste 26		Address: _____
Bethlehem, PA 18018		_____
Phone: 610-320-2366 Fax number: 610-379-2545		Phone: _____ Fax number: _____
Secure email: _____		Secure email: _____

C. Records to be disclosed:

- ❑ Social, family, developmental histories
- ❑ Assessments with diagnoses, prognoses, and recommendations, and all similar documents
- ❑ Academic or educational records
- ❑ Billing records
- ❑ Treatment attendance
- ❑ Other: _____

D. I authorize the transfer of these records for the following purpose(s) or uses:

❑ Further mental health evaluation, treatment, or care ❑ Treatment planning

❑ Qualification for services or benefits ❑ Other: _____

E. I authorize the Source named in section B above to share by telephone and/or face to face with the Recipient professional in section B any information that can assist with my/the patient's receiving treatment. I understand the consequences if I refuse to allow this release. My consent is fully voluntary. I understand that the Source of the information has no control of it after it has left the Source's premises. I understand that I may revoke this ROI authorization, but that doing this will not bring back the information that was released before the date of the revocation. I can do this at any time by writing to the Source named in section B. If I do not void or cancel this ROI authorization, it will automatically expire 365 days from the date I signed it. I have had the provisions of this form explained to me and believe that I fully understand this ROI.

_____	_____	_____
Signature of patient	Printed name	Date
_____	_____	_____
Signature of parent/guardian/representative if needed	Printed name	Date
_____	_____	_____
Signature of Witness	Printed name	Date

❑ Copy for patient or parent/guardian ❑ Copy for Source of records ❑ Copy for Recipient of records