STACEY SCHECKNER, PH.D.
PSYCHOLOGIST, LICENSE # PY 7217
South Tampa, Florida
(813) 362-3936

AUTHORIZATION FOR *RELEASE* OF CONFIDENTIAL INFORMATION

I, _____(your name), hereby give permission to:

Name/Degree: __**Dr. Stacey Scheckner/Ph.D.**_____
Address: _____
City/State/Zip: __**South Tampa, Florida**_____

To release information, including academic, medical, psychiatric, and psychological treatment contained in the records of:

Client Name: _____
Social Security: _____

Name of person, agency, or organization to which information is to be released:

Name: _____
Address: _____
City/State/Zip: _____
Phone Number:_____

Specific information to be released:

____ Treatment Summary
____ Discharge Summary
____ Educational Evaluation
____ Psychological Evaluation
____ Other
____ Academic Records
____ Psychiatric Records
____ Psychosocial History
____ Emergency Service
____ Lab Results

Date(s) of service for which information is requested: _____

Purpose of release of information: _____

I understand that said information may contain substance abuse and/or client disclosed HIV/AIDS information. This relates shall be in compliance with Federal Regulations (42CFR Part 2, 21 USC Section 290 odd-2), as amended and with all state and local laws, rules, and regulations. Information may not be re-disclosed without further authorization by the client/representative. This authorization shall remain in effect from the date signed below until _____ (expiration date or event).

I understand that:

- I may revoke this authorization in writing by contacting your office at the above address, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

__ If this line is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

_____ _____
Client Signature Date Witness Signature Date

_____
Parent/Guardian/Foster Parent Signature Date