Tyler C. Ralston, PsyD, ABPP

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AUTHORIZATION FOR RELEASE OF INFORMATION

This form, when completed by you, authorizes release of protected information from your clinical record to/from or between the persons you designate below.

I, _____ D.O.B. _____
Authorize the release of protected information from my clinical record:

Tyler C. Ralston, PsyD, ABPP
PO Box 10528
Honolulu HI 96816
Ph: 808-358-2982
FX: 888-484-0988

CIRCLE one or both

FROM TO ⟷

TO FROM ⟷

Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____

The purpose of this release is: (check all that apply):

_____ client request _____ coordination of care _____ discharge planning

_____ other (please specify): _____

_____ I also give my permission for the release of information regarding assessment, diagnosis and treatment of alcohol and/or substance abuse.

_____ I also give my permission for the release of information relating to confidential information and diagnosis and/or treatment of AIDS, AIDS related complex (ARC) or HIV status.

This authorization shall remain in effect until:

_____ Termination of services _____ Date: _____ _____ 12 months after the date of my signing this form.

I understand that this Authorization to release health information is voluntary. I have the right to revoke this Authorization, in writing, at any time by sending such signed, written notification to the office address. However, my revocation will not be effective to the extent that action has been taken in reliance on the Authorization. I understand that information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule. I agree to pay $300.00 per hour, and/or a prorated fraction thereof for less than an hour, plus tax, for the preparation of the materials and hereby hold harmless my psychologist, Tyler C. Ralston, PsyD, ABPP from any liability relevant to the release of confidential information or privileged communication.

Client Signature _____ Date _____

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