Christopher Bauchman, Psy.D.
Licensed Psychologist
11000 Prosperity Farms Rd.
Ste. 202
Palm Beach Gardens, FL 33410
www.drbauchman.com
561-328-7567

Release of Information

This form authorizes a release of protected information from your clinical record to the person you designate.

Client Signature: Today's Date: DOB:

I authorize *Christopher J. BH. Bauchman, Psy.D., Licensed Psychologist* to release:

All mental health treatment notes, treatment plan sand assessment reports for the purposes of assessment and treatment planning.

This information should only be released to:

I authorize the party below:

To release all mental health treatment notes, treatment plans and assessment reports for assessment and treatment planning.

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This information should only be released to:

Christopher J. BH. Bauchman, Psy.D.
Licensed Psychologist

Information listed below has additional laws relating to their use and disclosure. I understand and agree that this information will be disclosed if I place my initials below

____Mental Health Information ____Information General Testing Information

____Drug/Alcohol Diagnosis Treatment and Referral Information ____ HIV/AIDS

- I understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

- This authorization shall remain in effect for the duration of my work with Christopher Bauchman, Psy.D. or unless I revoke it in writing.

- To revoke this authorization, please send a written statement to Christopher Bauchman, Psy.D, and state that you are revoking this authorization. This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance.

- I understand that Christopher Bauchman, Psy.D., generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA privacy rule.

Client Signature: Today’s Date: DOB: