



# The ADHD Center for Success

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## AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_ hereby authorize **Dr. Lori Rappaport** and the following to disclose information and/or records regarding myself or:

(Name of patient) \_\_\_\_\_ (Date of Birth) \_\_\_\_\_

Physician/Pediatrician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Teacher: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Other: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Other: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

Other: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

### *The following information may be disclosed:*

- |  |  |
|--|--|
| <input type="checkbox"/> All pertinent records/information reports       | <input type="checkbox"/> Psychological testing reports |
| <input type="checkbox"/> Psychological/Psychiatric treatment reports     | <input type="checkbox"/> Hospital records              |
| <input type="checkbox"/> Medical records                                 | <input type="checkbox"/> Family history                |
| <input type="checkbox"/> Educational/School records                      | <input type="checkbox"/> Laboratory tests              |
| <input type="checkbox"/> Diagnostic impressions                          | <input type="checkbox"/> Treatment Summary             |
| <input type="checkbox"/> Letter requested by patient (specify):<br>_____ | <input type="checkbox"/> Billing Records               |
|  | <input type="checkbox"/> Other (specify) _____         |

### *Disclosure of records is required for the following purposes:*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Psychological treatment  | <input type="checkbox"/> Court Request   | <input type="checkbox"/> Educational Planning   |
| <input type="checkbox"/> Medical evaluation       | <input type="checkbox"/> ADHD Evaluation | <input type="checkbox"/> Personal               |
| <input type="checkbox"/> Case review/Consultation | <input type="checkbox"/> Emergency Only  | <input type="checkbox"/> Other (describe) _____ |

In addition, I hereby authorize Dr. Lori Rappaport to provide information, both oral and/or written, upon request, to the above stated person or agency.

**NOTICE OF PROVIDER'S RIGHT TO WITHHOLD INFORMATION**

The representative of a minor patient shall not be entitled to inspect or receive copies of a minor's patient records with respect to records for which the minor has a right of inspection or where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. Provider may also choose to prepare a summary of the record rather than allowing access to the entire record. If Provider determines there is a substantial risk of significant adverse or detrimental consequences to the patient in seeing or receiving a copy of the mental health records requested above, Provider may decline to permit inspection or provide copies of the requested records. In such event, Provider will make a written record noting the date of this request and explaining Provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse detrimental consequences that Provider anticipates would occur to patient if inspection or copying were permitted. Provider shall permit inspection by or provide copies of the requested records to a licensed physician, licensed psychologist or other licensed behavioral health professional designated by patient.

**NOTICE OF RISK OF REDISCLOSURE**

If you authorize the disclosure of health information to someone who is not legally required to keep it confidential, it may be potentially redisclosed and may no longer be protected.

This consent shall automatically terminate one (1) year from the date of signing or on \_\_\_\_\_ , unless previously revoked as set forth below.

**NOTICE OF RIGHT OF REVOCATION**

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or your legal representative, and delivered to Dr. Lori Rappaport at her office address. You may deliver your revocation by any means you choose such as by personal delivery or U.S. Mail, but *not* by email, text messaging, or facsimile. Your revocation will be effective only when it is actually received. Your revocation will not be effective to the extent that Dr. Lori Rappaport or others have already acted in reliance upon this authorization.

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Patient's Signature

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Date

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Parent, Guardian or Authorized Representative of Patient

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Date

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Relationship-if signed by other than Patient