Stephens Psychological Services
sps@hushmail.com
612-251-7413

Consent for Release of Information

Name of Client: _____Date of Birth_____

This form authorizes Dr. Carol Stephens of Stephens Psychological Services to exchange Personal Health Information with designated family members, Nurse Practitioners and Doctors, or any other person that I designate here:

_____
_____
_____

The Personal Health Information (PHI) within my medical records may be exchanged, including, but not limited to, Psychological Evaluations, Progress Notes and Assessment. The purpose of this release is:

_____
_____

This information may be disclosed to the above persons, from records whose confidentiality is protected by Federal Laws and by Minnesota Statutes. I may revoke this authorization at any time in writing to Dr. Stephens.

This authorization will expire one year from the time of signing.

Signature of Client _____Date_____

Signature of Witness _____Date_____