



Robin Navarro, Psy.D., PLLC
Licensed Psychologist

Authorization for Release of Information

Client Name _____ Date _____

Date of Birth _____

I, _____, hereby authorize Robin Navarro, Psy.D., PLLC to exchange my medical records including any psychiatric, alcohol, or drug abuse information contained with _____ . Such release is limited to the following:

- | | |
|------------------------------|---|
| _____ Intake Information | _____ Progress Notes |
| _____ Billing Information | _____ Psychological Testing |
| _____ Treatment Plan & Goals | _____ Verbal Summary of Our Work Together |
| _____ Discharge | _____ Other: _____ |

This information is needed for _____ .

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. I understand there are laws and regulations governing the confidentiality of my medical records and data concerning my treatment; specifically, N.C. General Statute 122 and, if drug and alcohol related, federal regulations (42 CFR Part 2). I further understand the data cannot be disclosed without my written consent unless provided for in the Notice of Privacy Practices. The information disclosed may not be further disclosed or used for any purpose other than as stated in this authorization.

This authorization is valid until _____ .

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____