Cornerstone Psychological Services, Inc.
4018 Medina Road, Suite D, Medina, OH 44256
Ph: 330.722.4166, Fax: 330.725.5792

Authorization for Release of Information

By signing this form, confidential health information can be released to, received from, and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. Please refer to the practice's Notice of Privacy Practices for more detailed information.

Client Full Name _____ Date of Birth _____

Mailing Address _____ Phone No. _____

1. I AUTHORIZE Cornerstone Psychological Services to:
   ☐RELEASE ☐RECEIVE information to/from the SECOND PARTY as directed below:

SECOND PARTY

Name of Individual/Organization _____ Phone No. _____

Address _____ Fax No. _____

2. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:
   - ☐ Diagnosis
   - ☐ Treatment Plan
   - ☐ Course of Treatment
   - ☐ Assessment Reports
   - ☐ Clinical/Discharge Summary
   - ☐ All Records Except Psychotherapy Notes*
   - ☐ Consultation Reports
   - ☐ Initial Evaluation
   - ☐ Alcohol/Drug Treatment _____(initial)
   - ☐ HIV/AIDS-related information _____(initial)
   - ☐ Verification of attendance/participation
   - ☐Other: _____ _____

(*Psychotherapy Notes require a separate authorization form that cannot be combined with the rest of the records.)

3. PURPOSE OF DISCLOSURE:
   - ☐ Consultation (verbal)
   - ☐ Evaluation
   - ☐ Personal Use
   - ☐ Legal
   - ☐ Insurance/Health Benefits
   - ☐ Continuation/Coordination of Care
   - ☐ Other _____
4. Note any exclusions/limitations here: _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to disclose my records, and that I may revoke this Authorization at any time by providing a written notice to Cornerstone Psychological Services. However, I may not revoke this authorization if this Authorization was obtained as a condition of obtaining insurance coverage or is a result of information being created for a third party, at any time by providing a written notice to Cornerstone Psychological Services. The revocation shall be effective except to the extent that Cornerstone has already used or disclosed information in reliance on the Authorization. I understand that my information as checked above may be disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected. I am giving my consent freely and voluntarily, and the benefits and disadvantages or releasing the information, if known, have been explained to me. The recipient of this information may be charged for the service of releasing records There is no charge to send records directly to my health care providers. This consent form will expire on _____ (Date) or upon the following event _____, whichever comes first, unless earlier revoked by me in writing.

Client Signature _____ Date _____ Witness _____

Legal Guardian/Parent _____ Date _____ Date _____

(Clients under 18 years of age or a person having a guardian must also have a parent or guardian sign this form)

Relationship if not parent: _____