

**James Davidson Ph.D.**  
**Forensic and Clinical Psychology**  
4212 State Route 306 Suite 306  
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(440) 942-0100 Fax (440) 942-0104

**Authorization for Release of Information and Records**

I hereby authorize: Person/Entity Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

to release information and records for: Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**This disclosure is at the request of the individual named above for the purpose of completing a court ordered psychological evaluation or in the anticipation of litigation. All information released with this authorization is NOT confidential. The party indicates by signing this release that ALL rights and privilege to confidentiality are waived.** Information to be used or disclosed includes only those items checked below with respect to services provided from the date of intake to the last date of service. I understand that this authorization extends to all of the records/information designated below which may include educational records, medical records, treatment for behavioral health, alcohol/drug abuse, HIV/AIDS test results or diagnosis, Job and Family Service records, and court or police documents. The information to be released includes:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Intake information         | <input type="checkbox"/> Treatment plans          | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> Progress notes             | <input type="checkbox"/> Collateral communication | <input type="checkbox"/> Reunification plans   |
| <input type="checkbox"/> School transcripts         | <input type="checkbox"/> IEP and/or 504 documents | <input type="checkbox"/> Discipline records    |
| <input type="checkbox"/> Medical records            |   |  |
| <input type="checkbox"/> TPO/CPO                    | <input type="checkbox"/> Victim statements        | <input type="checkbox"/> Police Statements     |
| <input type="checkbox"/> Court Orders               | <input type="checkbox"/> Complaints               | <input type="checkbox"/> Probation records     |
| <input type="checkbox"/> Jail or DH records         | <input type="checkbox"/> Diversion plans/orders   |  |
| <input type="checkbox"/> Verification of employment | <input type="checkbox"/> Work discipline records  | <input type="checkbox"/> OTHER:                |

This authorization is limited to only that information that I have requested above to be used or disclosed to the James Davidson Ph.D.. I hereby release the Person or Entity and its employees from all legal responsibilities or liability that may arise directly or indirectly from the release, use or disclosure of educational, medical records and other health information in reliance on this authorization. I take sole responsibility that the information exchanged may be detrimental and damaging to me or to my legal position. Unless noted otherwise below, a photocopy or fax of this form and my signature is as valid as the original.

- Expiration:** I understand that unless I revoke this authorization earlier, this authorization will automatically expire 180 days, or according to the relevant state or federal law, from the date this authorization is signed.
- Re-Disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party.
- Certification:** I certify that I am (check whichever applies):  
 The individual, and the identification that I have provided is true and correct.  
 The individual's authorized representative, and that the identification and proof of authority that I have provided are true and correct. "My relationship to the patient is that of: \_\_\_\_\_".
- Revocation:** I have the right to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization.
- Copy:** I understand that I will receive a copy of this completed form upon request.

\_\_\_\_\_  
(Date)                      (Child Signature – 12 or older)                      (Individual or Parent/Guardian)                      (Date)

\_\_\_\_\_  
(Date)                      (Staff Member/Witness)                      (Print Last Name)

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.