AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I _____ DOB: _____
SS#:_____

Terry Molnar, Ph.D. to release protected health information concerning professional services received by myself or my minor child or legal charge (Print full name of minor child or legal charge :_____) to:

_____
(full name of professional or agency receiving information – please print)

_____
(address of professional or agency receiving information – please print)

_____
(address of professional or agency receiving information – please print)

This authorization for release of information includes, but is not limited to, case notes, written reports, results of psychological evaluations including psychometric test profiles and protocols, and any such records as may have been kept in the course of the client(s') evaluation, treatment, or contact with the person(s) named above. The release waiver specifically allows release of all medical records including mental health treatment, diagnosis, or other mental health consultation and including evaluation and treatment for substance abuse. The information may be released to Dr. Terry Molnar in written form, as copies of existing records, or by written or verbal report, either in person or by telephone, and may be sent through the mail or provided be telefax transmission or by email. A photocopy of this signed release waiver is valid as the original.

The undersigned has the authority to allow the release of information concerning the persons named above.

This release waiver becomes effective on _____, and is to remain in effect until _____, or until canceled by written notification to Dr. Molnar, signed by the client, or the client's legal representative.

_____ _____
Date Signature of patient or parent of minor or legal charge

_____ _____
Signature of witness If legal charge, provide description of such representative authority