Authorization to Release Information

Aaron Goldner Psy. D., LP PLLC -- 950 East Maple Road, Suite 214, Birmingham, MI 48009
Phone: 248-894-4935 – Email: DrG@Aarongoldner.com

Client Information

Client's Name: _____

Client's Date of Birth: _____

Client's social security number: ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___

I hereby authorize Dr. Aaron Goldner, Psy. D., LP or designee of Dr. Aaron Goldner, Psy. D., LP, PLLC (the "Releasing Party") to release or disclose documents containing health information to:

PLEASE WRITE THE NAMES OF INDIVIDUALS OR ORGANIZATIONS YOU WOULD LIKE DR. GOLDNER TO BE ABLE TO SHARE YOUR PRIVLEDGED HEALTH INFORMATION WITH:

1. _____

2. _____

3. _____

This authorization is made in accordance with federal and state law and is valid until:

PLEASE CIRCLE ONE

1. *The end of treatment or legal action*
2. Or, ends on this date: _____
3. Or, does not end. Includes all past, present and future periods.

I understand I may revoke this authorization at any time by sending a written revocation to Aaron Goldner, Psy. D., except to the extent it has taken action in reliance on the authorization. I understand that once my health information is used or disclosed, it may be subject to re-disclosure or release by the Receiving Party, may be used for medical treatment or consultation, billing or claims payment and may no longer be protected by federal or state law.

Information or purpose of information to be disclosed:

Any and All health information needed to facilitate assessment, diagnosis, treatment planning and treatment and additional: _____

But not the following information (anything you do not want released): _____

_____

_

If client is an adult:

Client Name (print): _____

Client signature: _____ Date: _____

If client is a minor:

Parent name 1 (please print): _____

Parent 1 Signature: _____ Date: _____

Parent name 2 (please print): _____

Parent 2 Signature: _____ Date: _____