Lauri L. Korinek, Ph.D., LLC, PC
Licensed Psychologist, Neuropsychologist

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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I (we), _____ [Insert Name of Client or Caregiver] authorize Lauri L. Korinek, Ph.D., PC, to release and obtain the following information:

Please initial each item to be released and/or obtained

_____Assessment/Evaluation
_____Client History
_____Nursing/Medical Information
_____Diagnosis
_____Toxicological Reports/Drug Screens
_____Educational Information
_____Discharge/Transfer Summary
_____Treatment Plan or Summary
____Other
_____Current Treatment Update
_____Progress in Treatment
_____Medication Management Information
_____School Behavior
____Presence/Participation in Treatment
_____Scheduling / Cancelling Appointments
_____ Billing/Payment Information
_____Continuing Care Plan

Pertaining to me and/or my child, _____Date of Birth_____

To and From: _____ _____
Name of doctor, school, clinic, hospital, family member, etc. Phone Number

_____
Street Address

_____
City State ZIP code

Please list any part/s of the record you do not wish to have released_____
Otherwise, your records will be released as specified above.

I understand that the purpose of this disclosure of information is to improve assessment and/or treatment planning, share information relevant to assessment and/or treatment, and when appropriate, coordinate treatment services. I may revoke this authorization at any time by sending written notification to Lauri L. Korinek, Ph.D., PC, at 9364 Teddy Lane, Suite 204, Lone Tree, Colorado 80124. Otherwise, this authorization will automatically expire one year from the date below. I understand that if Lauri L. Korinek, Ph.D., PC, has released information based on this authorization before I revoke it, Lauri L. Korinek, Ph.D., PC, cannot get the information back. I also understand that Lauri L. Korinek, Ph.D., PC, has no control over how the above specified recipient may disclose released information. I understand that a copy of this authorization may be used in place of the original. I understand that authorizing the disclosure of this information is voluntary. I understand that I can inspect the information to be disclosed and I will be provided a copy of this authorization for my records.

Signature of Client/Caregiver_____ Date_____
Signature of Psychologist_____ Date _____