Kari Berquist, Ph.D., BCBA-D
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Authorization for Release or Disclosure of Information

Client/Child Name: ______________________________ D.O.B: ___________________
Parent/Guardian Name: ____
Phone: ____
Address: ____

I, _____________________________ (child's legal guardian), hereby authorize the release of specified information included in my child's mental health record obtained in the course of psychotherapy treatment with **Dr. Kari Berquist** including, but not limited to, HIPAA Protected Health Information (PHI).

Please indicate below the ***outside individual, organization, facility or person(s)*** *whom you authorize to receive the Protected Health Information (PHI) on this form.*

Name of person, organization or facility to receive health information: _____________________

Address:____

Phone:____

Specific purpose of release:____

Specific information to be released: ____

I certify that this request has been made voluntarily and that the given information above is accurate to the best of my knowledge. I further declare that I have the legal authority to grant the above permission. I understand that I have the right to revoke this authorization, provided that I do so in writing, except to the extent that Dr. Berquist has already used or disclosed the information in compliance with this authorization. I understand that once Dr. Berquist exchanges information with the above-mentioned party she no longer controls how that information is disseminated. This authorization **will expire in one year** after the date is signed.

_________________________ _________________
Printed name of legal guardian Date

___________________________ __________________
Signature of legal guardian Relationship to client