Barbara Winter PhD PA
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STATEMENT OF RELEASE
AUTHORIZATION TO REQUEST AND/OR RELEASE INFORMATION

Patient Name_____DOB_____

I authorize Dr. Barbara Winter to request, release, and exchange confidential professional information, including personal, psychological, and medical records, as well as professional opinions, with:

_____

Name of Provider, Organization, or School

_____

Address-Phone-Email

SPECIFIC INFORMATION TO BE RELEASED

The following information may be released/requested/shared for continuity of care.

___ Intake Summary
___ Discharge Summary
___ Psychological Testing
___ Consultation/Case Coordination

TERMS OF AUTHORIZATION

- I understand that this professional communication authorization, which may include Educational, Psychiatric, and psychological information, is subject to revocation by me at any time.
- In the event I do not revoke this consent, this release will expire when the stated purpose for which the consent was given has been fulfilled or upon termination of my treatment with Dr. Winter.
- Signing this authorization is voluntary and not a condition for receiving treatment.
- Once disclosed to the above-named recipient, the information may be subject to re-disclosure and may no longer be protected under HIPAA.
- I am entitled to receive a copy of this signed authorization upon request.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Witness Date