John W. Davis, Ph.D., ABPP
Jessica W. Shenesey, Ph.D.
Kathleen T. Payne, Ph.D.

273 Azalea Road, Suite 2-413
Mobile, Alabama 36609
Tel. (251)343-0566, Fax (251)343-0120

Patient Name _____
DOB: _____ Today's Date: _____

I request and authorize Bay Area Psychology and Counseling to:

□Release the following information to: □Release the following information from:

Name _____
Address _____
Phone: _____Fax:_____

Release is for the purpose of:

□Continued care by other health care provider □Disability □School □Personal
□Insurance □Attorney □Other (please specify_____

Information to be disclosed if requested:

□One year □Two year's □Complete medical record □Billing statement □Other_____

I understood and agree that the information I am authorizing to be released may include:

1. AIDS/HIV test results, diagnosis, treatment and related information;
2. Drug screening results and information about drug and alcohol abuse and treatment;
3. Mental health information; and/or
4. Genetics testing; Unless otherwise requested

I further understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my treatment will not be affected if I do not sign this form.

I further understand that I may revoke this authorization at any time by notifying the releasing facility in writing, except to the extent that action has already been taken in reliance on it. Unless earlier revoked, this authorization expires automatically 90 days after the last visit to Bay Area Psychology & Counseling or after all insurance or third party claims have been paid or satisfactorily resolved, whichever occurs last.

I further understand that the person I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

I further understand that I may refer to Bay Area Psychology & Counseling's confidentiality policies.

RELEASE FROM LIABILITY: I release and agree to hold harmless Bay Area Psychology & Counseling (or other releasing party) and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accord with this authorization. I understand Bay Area Psychology & Counseling (or other releasing party) cannot be responsible for use or re-disclosure of information to third parties.

TO THE RECEIVING PARTY OF THIS INFORMATION: This information has been disclosed to you for the sole purpose(s) stated in this authorization. Any other use of this information without expressed written consent of the patient is prohibited. These records may be protected by federal regulation. If the healthcare services (including examination and drug screening) are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I should contact my (prospective) employer.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

Patient/Guardian_____Date_____