Thomas M. Brunner , Ph.D., Licensed Psychologist
6614 East Carondelet Drive
Tucson, Arizona 85710
520-296-8572
FAX: 885-3922

AUTHORIZATION TO DISCLOSE INFORMATION

1. I hereby authorize: (Name of person you wish to request information from or send information to)

Name: ______________________________
Address: ______________________________
Phone: ______________________________

to exchange behavioral health or educational information (both written and phone communication) with Thomas Brunner, Ph.D. regarding the following client:

______________________________ DOB: ______________
(Child's name)

I also agree that Dr. Brunner may conduct a classroom observation if necessary. _______ **(Initial)**

2. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the appropriate agencies. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: resolution of presenting problems. If I fail to specify an expiration date, event or condition, this authorization will expire in 12 months.

3. I understand that authorizing the disclosure of information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my behavioral health/educational information, I may contact Thomas Brunner, Ph.D. at 296-8572.

4. I understand that the disclosure of information and records authorized by the client is required for the following purpose:

- ❑ Coordination of treatment with another mental health care professional involved in your care
- ❑ Coordination of treatment with another type of health professional involved in your care
- ❑ Coordination with another type of professional (e.g., attorney)

5. I understand that the disclosure of information shall be limited to the following information:

- ❑ Assessment, diagnosis, treatment plan, compliance, test results and response to treatment
- ❑ General impressions of functioning
- ❑ Other______________________________

6. I understand that the specific uses of Protected Health Information (PHI) to be discussed or released are as follows:

- ❑ Coordination of response to psychotropic medications prescribed
- ❑ Coordination of other medical treatment with mental health, marital, or family treatment
- ❑ Coordination of marital or family treatment with individual treatment
- ❑ Case management and/or utilization review under a managed care agreement.
- ❑ Other ______________________________

X______________________________ ______________
Signature of Parent or Legal Representative Date