

**BENSON PSYCHOLOGICAL SERVICES, PC**  
**1308 23<sup>rd</sup> Street South**  
**Fargo, ND 58103**  
**Phone (701) 297-7540**  
**Fax (701) 297-6439**

**AUTHORIZATION TO DISCLOSE INFORMATION**

**INSTRUCTIONS:** Provide information as it existed when the service was provided.

Name of Client: (Last, First, Middle Initial)	Phone Number:	Date of Birth:
Street Address:	City:	State/Zip Code:

**CLIENT RELEASE AND SIGNATURE:**

<b>1. I Hereby Authorize</b>			
Name of Person/Agency: <i>Benson Psychological Services, PC</i>			
Street Address: <i>1308 23<sup>rd</sup> Street South</i>	City: <i>Fargo</i>	State: <i>ND</i>	Zip Code: <i>58103</i>
<b>2. To Release Information To, Receive Information From, Or Mutually Exchange Information With</b>			
Name of Person/Agency to Receive Information:			
Street Address:	City:	State:	Zip Code:
Communication is Allowable By:			
<input type="checkbox"/> Phone Call	<input type="checkbox"/> Text Message		
<input type="checkbox"/> Email	<input type="checkbox"/> Face to Face		
<input type="checkbox"/> Written Correspondence	<input type="checkbox"/> Other		
<b>3. The Following Information is Requested:</b>			
<input type="checkbox"/> Communication Exchange in Verbal and Written Form	<input type="checkbox"/> Educational Evaluation/Report		
<input type="checkbox"/> Medical/Physical Reports	<input type="checkbox"/> Psychological Evaluation/Recommendations		
<input type="checkbox"/> Notice of Initial Contact	<input type="checkbox"/> Legal History/Reports		
<input type="checkbox"/> Addiction Evaluation/Recommendation	<input type="checkbox"/> Psychiatric Evaluation/Recommendations		
<input type="checkbox"/> Results of Any Drug Screening	<input type="checkbox"/> Reason for Referral		
<input type="checkbox"/> Discharge or Treatment Summary	<input type="checkbox"/> Treatment Program Reports		
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Other (Specify)		
<b>4. The Information Identified Above Will Be Used For:</b>			
<input type="checkbox"/> Coordination of Services	<input type="checkbox"/> Obtaining Collateral Information		
<input type="checkbox"/> Legal Proceedings	<input type="checkbox"/> Treatment		
<input type="checkbox"/> Evaluation and Program Determinations	<input type="checkbox"/> Other (Specify)		

**CLIENT CONSENT:**

<b>This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission.</b>		
Signature of Client:	Date:	Expires:
Signature of Parent/Guardian or Custodian (if needed and relationship):	Date:	Expires:
Signature of Witness (if needed):	Date:	Expires:
<input type="checkbox"/> Check if Applicable - Notice To Whomever Disclosure Is Made Concerning Addiction Records		
<b>This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to investigate criminally or prosecute any alcohol or drug abuse patient.</b>		