JASON EVAN MIHALKO, PSY.D.
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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

_____ Date Effective: _____

Release information to: _____ Date(s) of Treatment: _____

_____

Please tick all that apply:

- ☞ Hospital Discharge Summaries
- ☞ Outpatient Mental Health Evaluation and Treatment
- ☞ Records of Medical Evaluation and Treatment
- ☞ Hospital Medical History and Physical Exam
- ☞ Psychological, Neuropsychological, Developmental
- ☞ Academic Testing Reports
- ☞ Telephone Consultation
- ☞ Laboratory Reports
- ☞ Neurological Consultation
- ☞ Records of Core Evaluation
- ☞ Other School Reports (please indicate)
- ☞ Other (please indicate)

Please release this information for the following purpose

- ☞ Mental Health Evaluation/Treatment
- ☞ Mental Health Examination/Assessment
- ☞ Weekly therapy
- ☞ Other (please describe)

Please release information to (tick both for two-way information sharing):

- ☞ Jason Evan Mihalko, Psy.D. 1208 Massachusetts Avenue, Suite 3 • Cambridge, MA • 02138
- ☞ Other (please indicate)

I have carefully read and understood the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records, including alcohol and drug abuse records, if relevant, to/by those persons/agencies named above. I understand that this information may be protected by Federal Regulation 42 CFR, Part 2. I understand that my protected health information used or disclosed pursuant to this authorization may or may not be subject to redisclosure by the recipient. I understand that this consent is subject to revocation at any time except after the information has already been released and will expire one year from the date signed. Consent may be rev if requested in writing to Jason Evan Mihalko, Psy.D. 1208 Massachusetts Avenue, Suite 3 • Cambridge, MA • 02138

_____ _____
Signature of Patient Date

_____ _____
*Signature of Parent or Guardian Date

*Relationship to Patient: ___Father _____Mother___ Other:_____
Parent only may sign for patients 15 years or under. Patient and parent must sign for patient 16-17 years old.

The information to be disclosed includes confidential information as initialed below:

_____Psychiatric Evaluation/Treatment
_____Alcohol/Drug Abuse (Past or Present)
_____HIV Test Results
_____STDs
_____Other