RKHS Psychological and Consulting Services

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Therapy, Evaluation, & Consultation

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**RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whose Date of Birth is \_\_\_\_\_\_, authorize Dr. Robin Holmes-Sullivan to disclose to and/or obtain from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following information: [Insert Name of Person or Title of Person or Organization]

**Description of Information to be Disclosed (Initial each item to be disclosed)**

\_\_\_\_\_ Assessment
\_\_\_\_\_ Diagnosis
\_\_\_\_\_ Psychosocial Evaluation
\_\_\_\_\_ Psychological Evaluation
\_\_\_\_\_ Psychiatric Evaluation
\_\_\_\_\_ Treatment Plan or Summary
\_\_\_\_\_ Current Treatment Update

**Purpose (Initial each item that applies)**

\_\_\_\_\_ Educational Information
\_\_\_\_\_ Discharge/Transfer Summary
\_\_\_\_\_ Continuing Care Plan
\_\_\_\_\_ Progress in Treatment
\_\_\_\_\_ Demographic Information

\_\_\_\_\_ Psychotherapy Notes

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

**Revocation**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Robin Holmes-Sullivan in writing at rhholmessullivan@yahoo.com or by mail.

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Signature of Patient/Client Date