BETHEL OLENTANGY PSYCHOLOGICAL SERVICES
An Association of Independent Practitioners
4949 Olentangy River Road
Columbus, OH 43214
Phone: (614) 451-6606
Fax: (614) 451-2923

Authorization for General Release of Information

Client Name:_____ Date of Birth: _____

In accordance with Federal Regulation 42 CFR, Part 2, I hereby authorize:

Bethel Olentangy Psychological Services
4949 Olentangy River Rd. Columbus, OH 43214
Phone: (614) 451-6606 / Fax (614) 451-2923

To release information to ☐ *To receive information from* ☐

Name: _____

Address: _____

Phone: _____ Fax: _____

For the following information: _____

For the specific purpose of: _____Further Care _____Evaluation
_____Insurance/Financial Matters _____Other

- I release all of the above named parties of any legal liability which may arise from the release of information requested.
- I understand that this authorization for the release of information will automatically expire after 1 year
- I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by myself.

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Relationship (if client is a minor):_____

Witness:_____