The SCOTT GROUP, PLLC

PSYCHOLOGICAL ASSESSMENTS

AUTHORIZATION FOR EXCHANGE OF INFORMATION

1. THE UNDERSIGNED HEREBY AUTHORIZES:

   The Scott Group, PLLC
   PO BOX 917
   Frankfort, KY 40602

   TO EXCHANGE INFORMATION FROM THE MEDICAL (HEALTH) RECORD OF:

   _____ (NAME)
   _____ (ID NUMBER)
   _____ (BIRTH DATE)
   _____ (DATES OF TREATMENT/SERVICE)

2. INFORMATION TO BE EXCHANGED WITH:_____
   (Person/Agency/Address)
   _____

3. TYPE OF INFORMATION TO BE EXCHANGED: _____

   _____

4. PURPOSE FOR EXCHANGE: _____

   _____

5. It is understood that this authorization for release is subject to revocation at any time, and that unless another date is specified this release will expire sixty (60) days after date it is signed.
   TIME LIMITATION OF EXCHANGE: _____

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PROHIBITION ON REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT YOU FROMMAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OFMEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARTY IS NOT SUFFICIENT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO VIOLATES ANY PROVISION OF THIS LAW SHALL BE FINED NOT MORE THAN $500, IN THE CASE OF A FIRST OFFENSE, AND NOT MORE THAN $5,000 IN THE CASE OF EACH SUBSEQUENT OFFENSE.

_____
Date

_____
Signature of Patient/Resident/Client

_____
Witness

_____
Signature of Patient's/Resident's/Client's Agent or Representative

_____
Expires

_____
Relationship

_____
Address

_____