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Authorization to Release Information

Client Name: _____

Date of Birth: _____

Address: _____

Phone: _____

City: _____

State: _____

Zip: _____

I authorize Mountain Brook Wellness (MBW) to: obtain from the following release to the following

Name/Facility: _____

Address: _____

City, State: _____ Zip: _____

Telephone: _____ Fax: _____ (Email): _____

The following protected health information:

Office Notes /Name of Physician _____ Outpatient Therapy Notes _____

History & Physical _____ Discharge Summary _____ Consultation Reports _____

Radiology CD Images (MRI/CT/x-ray) Radiology Reports _____ Lab Results _____

Other: (specify) _____

Date Range of Information to be Released: from ____/____/____ to ____/____/____
(month/year) (month/year)

Fax Copy Mail Copy Electronic Copy _____ Other _____

The purpose for this request to release medical information is:

Medical or Mental Health Client Care / Treatment Insurance Other (specify) _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information which may include confidential psychological information and/or records as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time by informing Mountain Brook Wellness (MBW) in writing, except to the extent that action has already been taken in reliance on it.
- MBW may charge an administrative fee to cover the cost of labor, copying, and postage. MBW will inform me of any charges and arrange for payment.
- This Authorization expires on ____/____/____ {if date not completed / **one year after signed**}
- In consideration of this authorization, I hereby release the above parties from any and all liability arising therefrom.

Client / Representative Signature

SIGN HERE

Date

If the client listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this client, please sign above and complete the following:

(Print Name of Parent, Guardian, or Representative)

(Relationship to Client)