Chris K. Wehl, Ph.D. ***Clinical Psychologist***
1263 E. South Temple ***Suite 9*** ***Salt Lake City, Utah 84102***
(801) 350-0115 Send encrypted documents via https://hushforms.com/chriswehl507

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION OR OTHER CONFIDENTIAL INFORMATION

I _____
full name of adult client or parent of minor child (please print)

AUTHORIZE _____
name of professional or agency releasing information (please print)

_____
_____
Address and email

to **release protected health information or other confidential information** concerning professional services received by myself and/or my minor child or legal charge:

_____
(Print full name of minor child if applicable)

To: Dr. Chris K. Wehl
1263 E. South Temple Suite 9
Salt Lake City, UT 84102

for the purpose of: _____
(Please print- If you are a current patient, "at patient request" is sufficient)
If the disclosure is for a custody or other court-related evaluation, be aware that requested information may appear in reports and/or be disclosed in testimony or deposition, or provided to involved attorneys

You may revoke this consent to release protected health information or other confidential information at any time, by written request to the professional or agency authorized above. Unless you revoke it, this authorization shall remain in effect for one year or until such time as specified herein:_____.

I understand that redisclosure of any information released prior to this revocation may have already occurred or may occur in the future without my knowledge or consent; therefore, the privacy of my personal and health information may no longer be protected by law.

I understand all of the aforementioned, and with informed consent and of my own free will, authorize this disclosure of protected health information or other confidential information.

_____ _____
Signature of Patient (or subject of evaluation) or Parent of Minor Date