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Authorization For Release of Health Information

This form when completed and signed by you, authorizes release of protected information from your clinical record to the person you designate.

Patient's Name: _____ DOB: _____

Address: _____

Phone Number: _____ Dates of Service: _____

I authorize _____ and/or his or her administrative and clinical staff to ___release/ ___obtain the following protected health information from my clinical record:

__Discharge Summary __Clinical Progress Notes __Lab Reports
__Psychological Eval __Psychiatric Eval __History and Physical Exam
__Psychotherapy Notes __Physician's Orders __Psychosocial History
__ Other _____
__ Two-way communication between releasing and releasing parties

This information should only be released to (name and address of person to whom the information is to be released).

_____
_____

I am requesting the release of this information for the following reasons: ("continuity of care" is generally appropriate or "at the request of individual" is all that is required if you are my patient and do not desire to state a specific purpose.)

_____

This authorization shall remain in effect for 60 days or until _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer be protected by the HIPAA Privacy Rule.

_____ _____ _____
Signature of Patient or Legal Guardian Date Witness Signature

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.