Authorization Form

Patient name: _____ **Birthdate**: _____

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

I authorize Psychology & Counseling Associates to release to and/or receive from:

_____

_____

_____

The following:

☐ Letters/telephone calls reporting my (or my child's) diagnosis, symptoms, history, progress, and treatment recommendations, and updates as needed.

☐ All medical records ☐ Other _____

The purpose of the request is to: ☐ provide coordination of care ☐ at request of patient

☐ other (please specify) _____

This authorization shall remain in effect for:

3 months after termination of treatment or until _____ (fill in date or relevant event):

You have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, your revocation will not be effective to the extent that we 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 Psychology & Counseling Associates generally may not condition (withhold or refuse) 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 (e.g. psychological report).

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

☐ I do not want a copy of this form. ☐ I want a copy of this form.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of parent/guardian for a minor **Date**

Prohibition of Redisclosure: Confidential health care information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws, including HIPAA, prohibit you from making disclosures of this information unless further disclosure is expressly permitted by the written Authorization of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Therapist use only (for PCP's):

Th_____Dx_____Eval date_____ Loc: P C M

Additional info _____

_____

_____