Associates in Health Psychology LLC

AUTHORIZATION FOR EXCEPTIONAL DISCLOSURE

I, _____, authorize _____, a therapist at Associates in Health Psychology, LLC, to release and/or obtain protected information in medical records for myself (DOB: ___/___/_____) OR for a minor child (Child's name: _____ DOB: ___/___/_____).for the purpose described below. I understand that this authorization is voluntary and that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal privacy regulations. ***However, any disclosure of information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment or diagnosis, and which would identify a patient as an alcohol or drug abuser, permitted hereunder shall be accompanied by the following written statement: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."***

This information may include diagnoses, treatment information and other notations; substance abuse information; and information on AIDS/HIV status.

Client Address & Phone Number: _____

_____

Persons/organizations **providing** the information: _____
of **Associates in Health Psychology, LLC.**

Persons/organizations **receiving** the information: _____

Address & Phone Number: _____

_____

Specific description of the information to be disclosed or used (includes dates): _____

_____

What is the purpose of the use or disclosure? _____

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that I may see and copy the information described on this form if I ask for it, and that I can get a copy of this form after I sign it. I understand that this authorization will expire one year from date of signature. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.

Signature of Client or Client Representative/Guardian: _____ Date: _____
Print name of Client or Client Representative/Guardian: _____
Relationship to the Client: _____

- You may refuse to sign this authorization
- You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

25 Omega Drive, Bldg. J, Ste. 25, Newark, DE 19713
(302) 428-0205 • Fax: (302) 428-1123 • www.**AHP**Delaware.com