Associates in
Health Psychology
LLC

AUTHORIZATION TO RELEASE INFORMATION: ADULT

I, _____, Date of Birth _____,
(Your Name)

authorize _____,
(Name of Provider at AHP)

of **Associates in Health Psychology, LLC,** to release/obtain information in my medical records

to/from :_____
(Your Therapist's, Primary Care Physician's, or Specialist's **Name, Address, Telephone** and **Fax Number**)

for the purpose of_____

_____.

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

I understand that this information released by this consent is voluntary and it may be revoked by me in writing at any time. The revocation of this consent will not apply to information released prior to my revoking this consent. This consent if not withdrawn will be valid for the duration of the related treatment and billing requirements.

Please note that the released information may not be protected by HIPAA privacy and security rules once it has been forwarded beyond our facility to the intended recipient. You have the right to refuse this disclosure to any outside entity listed above or restrict where information may be sent. Please note your restrictions, or refusal here: _____.

Your therapist has the right to refuse your request for restrictions, but if he/she agrees they are bound by that agreement.

_____ _____
Client's Signature Date

_____ _____
Therapist's Signature Date

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