Associates in
Health Psychology
LLC

AUTHORIZATION TO RELEASE INFORMATION

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

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: ___/___/_____).

This release of information pertains to only the following person *(circle and provide contact information)*:

Primary Care Provider ***Psychiatrist*** ***Medical Specialist*** ***Therapist*** ***Teacher*** ***Other***: _____

Name: _____ Phone: _____

Address: _____ Fax: _____

The purpose of this release is *(circle one):* ***Coordination of care*** ***Evaluation Results*** ***Background Information***

At the request of the client/parent/guardian ***Other***:_____

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

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the AHP office address. However, your revocation will not be effective to the extent that AHP has 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. This consent, if not withdrawn, will be valid for the duration of treatment and billing requirements.

I am aware of my right to confidential communications under psychologist-patient privilege.

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

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the services are provided for the purpose of creating health information for a third party.

Any facsimile, copy, or photocopy of this Authorization shall have the same effect as the original.

_____ _____

Signature of Client or Parent/Guardian Date

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