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AUTHORIZATION TO USE, RELEASE, AND OBTAIN PERSONAL HEALTH INFORMATION

I, _____ , authorize _____ to: _____ (release) _____ (obtain) the protected health information listed below _____ (to) _____ (from) the following agencies or people

Name: _____

Agency: _____

Address: _____

Phone: _____

1. This request and authorization applies to only the following protected health information:

_____

_____

_____
(description should be as specific and detailed as possible)

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

_____

_____

_____

4. This authorization shall remain in effect until: _____

_____

(expiration date or expiration event related to the individual or the purpose of the use or disclosure)

5. 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.

6. 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.

7. 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 or state privacy laws.

   If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from redisclosing any HIV related information unless permitted to do so by federal or state law.

8. I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

9. I understand that I have the right to refuse to sign this authorization.

Please sign below to authorize the use or release of your personal health information for the reasons set forth above:

_____

Signature of Patient or Patient's Personal Representative, if applicable

_____

Name of Patient or Patient's Personal Representative, if applicable (please print)

_____

Description of Authority of Patient's Personal Representative, if applicable

_____

Date