

Authorization Form For Release of Information

This form when completed and signed by you, authorizes the mutual exchange of protected information from the clinical record of _____ to the person you designate. (Patient's Name)

I authorize my psychologist, _____ (2450 Delaney Avenue, Wilmington, NC 28403, 910-763-9512) and/or his or her administrative and clinical staff (cross out if not applicable) to exchange the following:

- _____ Full Clinical Health Information Record
- _____ Test Data Only (Name Tests) _____
- _____ Information specifically named: _____

This information should only be exchanged with (name and address of person to whom the information is to be exchanged):

Name: _____

Address: _____

Phone: _____ FAX: _____

I am requesting this exchange for the following reasons: ("at the request of the individual" is all that is required if you are the patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect for _____ or until _____
(mo., year, etc.): (mo., year, etc.):

I have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, my revocation will not be effective to the extent that my psychologist has already 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 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.

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

Signature

Date

(Print name of signer)

(Relationship to Patient)

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

(Photocopies of this form are acceptable.)