

# Authorization Form

(please check all applicable boxes)

1.  I am completing this form to allow the use and sharing of protected health information about:

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

2.  I authorize \_\_\_\_\_ (name of group),  
the administrative staff, and

\_\_\_\_\_  
Name of Therapist

\_\_\_\_\_  
Name of Therapist

3. To obtain or disclose the following information:

- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Complete copy of the medical record.
- Academic and educational records, including achievement and other tests results, reports of teachers' observations, and all other school or special education documents.
- Billing records.
- Other \_\_\_\_\_.

4.  To the following person or organization:

- From the following person or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Patient's Relationship to this Person: \_\_\_\_\_

- 5.  This release shall permit my therapist \_\_\_\_\_ (name) to speak directly to the party or organization named in Paragraph 4 concerning my care as provided in Paragraph 3 of this Authorization.
  
- 6.  I authorize my therapist \_\_\_\_\_ (name) to testify regarding the provision of psychological services to me at any deposition or hearing in which I am a party.
  
- 7. The information will be used/disclosed for the following purposes:
  - at the request of the individual, or
  - other \_\_\_\_\_.
  
- 8.  I understand and agree that this Authorization will be valid and in effect until \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (enter a date upon which this Authorization expires.) I understand that after that date no more of this information can be used or released to the person or organization unless I sign a new Authorization.
  
- 9.  I understand that I can revoke or cancel this Authorization at any time by sending a letter to \_\_\_\_\_ (name of group or therapist). If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
  
- 10.  I understand that my therapist 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.
  
- 11.  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.

\_\_\_\_\_  
Signature of Patient or his/her Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Description of Personal Representative's authority