AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Patient Rights: You may end this authorization (permission to use or disclose information) at any time by writing to the address below. If you request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits. You have a right to a copy of this signed authorization. If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization: I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

I hereby authorize Advanced Psychological Solutions to RELEASE/OBTAIN my protected health information (PHI) to:

Name: _____ P:_____ F: _____
Name: _____ P:_____ F: _____
Name: _____ P:_____ F: _____
Name: _____ P:_____ F: _____
Name: _____ P:_____ F: _____

This information is being requested for the purpose of: _____

_____

_____

Disclosure Scope for PHI Release: Disclosure may include the following verbal or written information:

☐ Medical History	☐ Physical/Labs/Diagnostic Testing	☐ Neuropsychological Eval	☐ Treatment/Care plan
☐ School/Vocational	☐ Alcohol/Substance Information	☐ Assessments/Evaluations	☐ Discharge Summary
☐ Social/Family	☐ Psychiatric/Psychological Eval	☐ Progress and Case Notes	☐ Other:

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect for:

- The period necessary to complete all transactions on accounts related to services provided to me.
- One (1) year
- Other: _____

If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian, Parent (if minor), or Personal Representative Date

Relationship to Patient: _____

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