Integrative Psychotherapy and Assessment Services

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Authorization for Release of Healthcare Information

Patient Name: _____ Date of Birth: _____

The person above is or has been a patient. The above person must indicate when this authorization is to expire:

☐ When the information is received ☐ Six Months ☐ In One year ☐ In Three Years ☐ On Date:

The person named above hereby authorizes _____ to:

☐ Request health information from ☐ Send health information to ☐ Exchange verbal health information with

Name of Person: _____ Provider or Facility: _____

Address: _____ Phone: _____ Fax _____

Scope: ☐ All information regarding assessment, diagnosis and treatment of patient's condition, concern or disease (specify):

☐ All information regarding care received by patient between the dates of _____ and _____. ☐ Treatment Plan

☐ Assessment reports, evaluations, diagnosis ☐ Treatment Plan Review ☐ Progress Notes ☐ Lab Results

☐ Current Medications ☐ Recommendations ☐ Other information (specify):_____

Purpose: ☐ Coordination between Treatment Providers ☐ Personal Records ☐ Legal Proceedings ☐ Other (specify):_____

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information the person named must initial and date each item. If an item is not initialed and dated the information if such exists cannot be released or discussed.

Initial	Information to Shared	Date Range (list date range)
_____	Alcohol or Drug Use/Abuse Treatment	to
_____	Mental Health Treatment	to
_____	HIV Status or Treatment	to

Please note: Unless otherwise specified by law, we release only information which has been created by our employees or agents, including chart notes, lab results, summaries and consultation reports. Records created by and available from other providers, hospitals or other care facilities must be obtained directly from those other providers or facilities. There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand I have the right to inspect the information you authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand the information I am authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures may not be prohibited by law. We are not responsible for the actions of others who may be provided with the information released as a result of this authorization. Please consider a facsimile copy of this authorization to release records to be as effective and valid as the original signed by me.

Authorization: Signature of Patient: _____ Date: _____
or Authorized Representative

Signature of Witness: _____ Date: _____

If not signed by the patient, indicate relationship of authorizing person to patient:

☐ Parent or Guardian of minor child ☐ Guardian or conservator of conserved patient ☐ Beneficiary or personal Representative of a deceased individual