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Authorization for Disclosure/Exchange of Information

Re: _____ Birthdate: _____

This form when completed and signed by you, authorizes us to release and/or receive protected information from your clinical record or the record of the person for whom you are guardian, to the person you designate.

I authorize my psychologist Fredric Provenzano, Ph.D., NCSP and/or his or her administrative and clinical staff to share the following: (Describe the information you want disclosed. Please be as specific and detailed as possible.)
_____ Information only TO Dr. Provenzano
_____ Information only FROM Dr. Provenzano
_____ Exchange of information between Dr. Provenzano and the listed party

To be disclosed**:** _____

This information should only be disclosed, as per the instructions above, to/from the following:

Name: _____

Organization: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Reason for Request:
_____ Coordination of Care_____ Authorization of Treatment _____Claims Processing
_____ Other (describe): _____

This Authorization shall remain in effect until (date) _____ or until the event listed below that relates to the purpose of the disclosure. In any case, it does not permit disclosure of my future health care given more than 90 days from the date of this Authorization (unless this is for disclosure to insurance companies). *If this Authorization does not contain an expiration date, the Authorization expires **90 days** from the date of my signature.*

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that the psychologist has taken action in reliance on my authorization, or if this Authorization was obtained as a condition of obtaining insurance 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 also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient/Guardian Date

_____
Co-Signature (if requested)

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.