Authorization to Release Information to Physician

Client name: _____ DOB: ___/___/___

This form when completed and signed by you, authorizes us to release and/or request protected health information from your clinical record to/from the person you designate.

I, _____authorize Pike Creek Psychological to do the following:
(your name here)

Do you authorize Pike Creek Psychological Center to release & request information regarding your treatment to/from your physician? *Please check yes or no.*

☐ **Yes,** I authorize PCPC to release/request information to/from my physician.

☐ **No,** I refuse to have any information released to my physician.
Please leave other sections blank & sign at bottom

To whom should we release/From whom should we request your information?

Name:_____Attn:_____
Address:_____
Phone:_____Fax:_____

What is the purpose of releasing/requesting this information?

☐ At the request of the individual
☐ Continuity of care (To provide good care)
☐ Other:_____

When should this authorization expire?

_____
*Please write "**At end of treatment**" for continuity of care, or if desired, write a specific:*
_____/_____/_____
Expiration date

- You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that PCPC has 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 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.
- 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.
- I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.
- However, any disclosure of information that pertains to the treatment or diagnosis of drug abuse or alcohol abuse or a referral for such treatment or diagnosis, and which would identify a patient as an alcohol or drug abuser, permitted hereunder shall be accompanied by the following written statement: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." A general authorization for the release of medical or other information is NOT sufficient for this purpose. Thus we include the following:
  - I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, genetics, transgender, and/or psychiatric diagnoses compiled during my visit, or make copies thereof in accordance with the policies of this facility. **(Check one below.)**
    - ☐ Yes I agree to the release of my medical or billing records containing the sensitive information listed above.
    - ☐ No I do not agree to the release of my medical or billing records containing the sensitive information listed above.
- Any facsimile, copy, or photocopy of this authorization shall have the same effect of the original.

Client signature: _____**Date:** _____

(If client is a minor, signature & relationship of financially responsible person is required below.)

Signature of financially responsible person: _____
Name of financially responsible person: _____
Relationship to client: *(please check one)* ☐Parent ☐Legal guardian ☐Other: _____