

Western Reserve Psychological Associates, Inc.

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Authorization Form

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

I, _____ (Patient's printed name) _____ (Patient's date of birth), authorize

(Psychologist's Name) at Western Reserve Psychological Associates, Inc.
and/or his or her administrative and clinical staff:

- To **disclose** protected health information to the individual named below
To **obtain** protected health information from the individual named below
To **exchange** protected health information with the individual named below

Name of Individual _____ Phone: _____

Address _____ Fax: _____

City, State, Zip _____

Type of Information to be Disclosed/Obtained/Exchanged:

- | | | | |
|-------------------------------|--------------------------|--------------------------|--------------------------|
| Treatment Summary | <input type="checkbox"/> | Medication(s) | <input type="checkbox"/> |
| Diagnosis | <input type="checkbox"/> | Alcohol/Substance Use | <input type="checkbox"/> |
| Psychological Testing Results | <input type="checkbox"/> | School/Education Records | <input type="checkbox"/> |
| Hospital Records | <input type="checkbox"/> | Appointments Kept | <input type="checkbox"/> |

Other _____
(Provide a description of the information to be disclosed. The description should be specific and detailed.)

Purpose of Release: Coordination of Treatment
Other (please specify): * _____
*At the request of the individual is all that is required

Release Format(s) Verbal Communication
 Written
 Electronic Media (Fax) for urgent needs only

Expiration Date: _____ or until (event) _____
90 Days (date) (specify event)

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 we have 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 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 have the right to copy and to inspect the information disclosed and have the right to receive the practitioner's Notice of Privacy Information Form.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and may no longer be protected by the HIPAA Privacy Rule.

I have read and understand the above information and give my authorization voluntarily.

Patient Signature Date

Parent/ Guardian Signature Date

Parent/Guardian (Please Print Name)