PEDIATRIC PSYCHOLOGY ASSOCIATES

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PSYCHOLOGICAL RECORDS AND PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **DOB:** _____

I, undersigned, voluntarily request and authorize the personnel at Pediatric Psychology Associates (PPA) to obtain from and/or release to the agency(ies)/individual(s) I have indicated below the information contained in my and/or my family's clinical and medical record. I authorize PPA to release and/or obtain this private information verbally, in writing and/or electronically. I understand the purpose of the release/sharing of information may include clinical information, treatment planning, consultation, protection of self or others, coordinating interventions, educational planning, billing and collections, etc.

Check all that apply: I hereby authorize PPA _____ to release to and _____ to receive information from:

Name/Agency	Contact Information (address, phone, email, fax, etc.)

I authorize PPA to (check one):

[ ] Release any or all medical records

[ ] Release specific information- please list here_____

_____

This authorization shall expire on (please check the box that applies):

[ ] Date ____/____ /_____ [ ] Treatment Termination [ ] No Expiration Date

By signing below, I agree to the exchange of the above information. I acknowledge that the nature of this information has been discussed with me in a manner that I understand, and that I have had an opportunity to have any questions regarding the above exchange of information explained to me. I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations. I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to one of PPA's offices.

Signature of Patient/Authorized Representative _____

Printed Name of Signer _____ Date _____