PEDIATRIC PSYCHOLOGY
ASSOCIATES

Patient Name: _____ **DOB:** _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PSYCHOLOGICAL RECORDS AND PROTECTED HEALTH INFORMATION

This form when completed and signed by you, authorizes us to release and/or receive protected information from your (or your child's) clinical record to the person or agencies you designate. You agree and understand that this form does not constitute a general release, and that by checking off or specifying information below you are agreeing to an informed release of specific sensitive and confidential information.

I am requesting the release of this information for the following reasons: (please check one)

_____At the request of the patient or authorized representative

_____For treatment care coordination

TO PROVIDE INFORMATION - This information may be released by sending copies, facsimile, by phone or in person and should only be released to (name and address of person(s) or agencies to whom the information is to be released):

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

TO RECEIVE INFORMATION - This release shall authorize the following individuals or agencies to release the above specified by sending copies, facsimile, by phone or in person information to Pediatric Psychology Associates:

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

Patient Name: _____ **DOB:** _____

My check marks below authorize Pediatric Psychology Associates and/or its administrative and clinical staff to release or receive the following checked items in their entirety or additional information as indicated below:

Release to Outside Agencies or Individuals	**Release from Outside Agencies or Individuals**	**Specific Information**	**Release to Outside Agencies or Individuals**	**Release from Outside Agencies or Individuals**	**Specific Information**
		Intake Summary/Mental Status Exam			Hospital Records
		Discharge/Treatment Summary			Correspondence with Referral Source or Treating Providers
		Treatment Plan			Collateral Information
		Diagnosis			Psychological/Neuropsychological Test Results
		Progress Notes (Past, Current, and Future)			Other-Specify:
		Educational and Academic Records			Other-Specify:
		Release any of the specific information listed above	***Signature required for this option-Sign here***		

____ This authorization shall authorize for release of information from_____ to _____.
____ This authorization shall authorize for release of information from _____ until 120 days following the termination of therapy or closure of my case or file with Pediatric Psychology Associates.

You have the right to revoke this authorization in writing at any time by sending such written notification to one of our offices. 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.

By signing below you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. You are indicating that you understand that Pediatric Psychology Associates 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 understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

Signature of Patient or Authorized Representative _____

Printed Name of Signer _____ Date _____

Witness _____ Date _____

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.

ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED:

If you have received this information in error please contact our office as soon as possible to arrange for the return of the received material. This information may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed by law.