ASSOCIATES IN FAMILY PSYCHOLOGY
Serving Individuals, Couples and Families

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Authorization Form for Release of Protected Health Information

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

I authorize my psychologist,_____ and/or his or her administrative and clinical staff to:

☐ release information to and / or from: *☐send email to & from: _____
***Note:** Emails are not a secure form of communication. Please see page 5 of Service Agreement for informed consent details.*

Name: _____Phone: _____ Fax: _____
Address: _____ City: _____ State: ____ Zip: _____

about ☐ myself, ☐ spouse, or ☐ child *(Name(s)):* _____
_____
_____

I am requesting that this information be released for the following reasons: *(Circle choices or describe below.)*

Coordination of care At the request of the individual Appointments and Billing
Or specify details:
_____
Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This authorization shall remain in effect until ____/____/____ or revoked in writing.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining or utilizing 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 understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signed: _____ Print Name: _____ Date: ___/___/___

Signed: _____ Print Name: _____ Date: ___/___/___
Signature of Client or Signature of Parent, Guardian or Legal Representative if client is a minor .