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Ridgeland, Mississippi 39157
(508) 980-5225 (Phone)

Psychological and Assessment Services, LLC

Family Works, LLC Consent to Release Protected Health Information (PHI)

Client's Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

I, _____, authorize _____ to communicate via phone, fax, and email with:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize the release of the following information:

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES, HIV/AIDS STATUS, and SUBSTANCE USE AND ABUSE INFORMATION.

_____ IEP and academic testing results
_____ Behavior programs
_____ Progress reports
_____ Substance use and abuse evaluations
_____ Medical record
_____ Personality profiles
_____ Psychological reports
_____ HIV/AIDS Status and Information
_____ Service plans
_____ Summary reports
_____ Vocational testing results
_____ Entire record, except progress notes
_____ Psychotherapy notes
_____ Other (specify): _____

Initial here if you are allowing verbal and written **two-way communication** of protected health information between the people/parties listed above. _____

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program
_____ Facilitating communication with Primary Care Physician to integrate care
_____ Continuing appropriate treatment or program
_____ Determining eligibility for benefits or program
_____ Completing psychological testing report and obtaining background information
_____ Third-party insurance audit of entire record, including therapy notes
_____ Other (specify): _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ____Self ____Parent/legal guardian *(if joint custody, must provide court documentation and have consent of both parents/guardians) ____Legal representative ____Other (describe):_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ____/ ____/ _____

Parent/guardian/legal representative (if applicable)

Signature: _____ Date: ____/ ____/ _____

Witness Signature: _____ Date: ____/ ____/ _____