Psychological Associates of Central Florida

Psychological, Neuropsychological, and Forensic Services

Authorization for Release or Exchange of Confidential Information

Patient: _____ Date of Birth: _____

I authorize **Psychological Associates** to ☐ release ☐ receive the following information (check all that apply):

- ☐ Results of psychological and/or educational testing
- ☐ Counseling/psychological treatment
- ☐ Psychiatric
- ☐ Medical information
- ☐ Educational
- ☐ Legal
- ☐ Other information (Specify: _____)

I authorize **Psychological Associates** to exchange the specified information with the following entity:

Name/Agency: _____

Address: _____

_____

Phone/Fax: _____

Purpose of Disclosure:

- ☐ Continuing care
- ☐ At the request of patient/patient's parent or guardian
- ☐ Other: _____

This authorization shall remain in effect until _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that **Psychological Associates** has 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 **Psychological Associates** generally may not condition services upon my signing an authorization unless the services provided to me are 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.

_____ _____

Signature of Patient or Parent/Guardian of Minor Patient 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.

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