Center for Psychological Health and Wellness, LLC

122 West Lancaster Ave, Suite 206
Shillington, PA 19607
484-509-0499

REQUEST/AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name: _____ D.O.B. _____

By signing this form, I freely give permission to the Center for Psychological Health and Wellness, LLC to release information [circle one or both] **to** or **from** the following:

_____

_____

I authorize the following Protected Health Information to be released [circle items below]:

- Presence in treatment
- Background history
- Course in treatment
- Medical Records
- Psychological Evaluation
- Treatment Plan
- Discharge Summary
- Educational Information
- Other_____

I authorize this release for the purpose of [circle items that apply]

- Facilitate continuity of care
- Supplement
- Facilitate follow-up care
- Inform significant others
- Update medical records
- Apply for insurance
- Settle insurance claim
- Complete disability claims
- Other_____

My consent for the sharing of information is only valid for the person(s) or organization(s) named above, as well as for the purposes indicated. The information may be released in telephone conversations, mail, email, fax, or personal contact. This authorization will expire in 180 days or earlier, upon written request to my therapist/psychologist. If I do revoke this authorization, it will prevent any further release of information after the date of my written request but will not change the fact that some information may already have been sent or shared before that date.

I understand that if the person or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by HIPPA federal privacy regulations. I also understand that Center for Psychological Health and Wellness, LLC has no control over how Protected Health Information is used or managed after it is shared with others per this agreement, and agree to not hold Center for Psychological Health and Wellness, LCC liable for damages.

_____ _____
Signature of client age 14 and over Date

_____
Printed name of client age 14 and over

_____ _____
Signature of parent/legal guardian Date