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AUTHORIZATION AND REQUEST FOR THEAPY RECORDS
(HIPAA COMPLIANT FORM)

PATIENT NAME: D.O.B:

ADDRESS: TELEPHONE:

I hereby authorize Laurie Appel, PsyD, to disclose my health information to:

The information to be disclosed to and used by the above is for the following purpose:

Collaboration of Treatment
Insurance reimbursement
Treatment request authorization

This authorization is limited to the following dates of treatment:

FROM _INITIAL DATE OF TREATMENT TO PRESENT TIME

Information to be disclosed: True and complete copies of all records and information including:

1. intake records,
2. patient history,
3. admission records,
4. hospital records,
5. diagnostic test results [including psychometric tests, raw data, computerized reports],
6. progress notes,
7. billing records and EOBs,
8. consultation reports,
9. discharge records.
10. treatment request forms

l understand that the Information to be disclosed includes my identity, diagnose and treatment including ALCOHOL,DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipients prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that this revocation will not apply to the extent that the above physician/facility has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or condition: One Year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Heath Information Management Department.

PATIENT SIGNATURE: _____ DATE: _____

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE: _____ DATE: _____

RELATIONSHIP: _____