Springfield Psychological *Helping you find the right path.*

Authorization for Release of Confidential Medical Information

I, _____hereby authorize Springfield Psychological to:
Patient Name (Print)

□ **RELEASE Medical Information TO**:
Facility/Provider Name: _____
Address/Phone/Fax: _____

Facility/Provider Name: _____
Address/Phone/Fax: _____

the following information (please check all that apply):
□ Psychotherapy Notes □ Psychiatry Notes □ Assessment/Testing Notes □ Other_____
_____
Please provide specific dates and information that you are requesting

Purpose of Disclosure (Please select one only):
□ Transfer of care with another provider or facility □ Personal Copy **there is a charge if requesting for self**
□ Other _____

□ **OBTAIN Medical Information FROM**:
Facility/Provider Name: _____
Address/Phone/Fax: _____

the following information _____

Purpose of Disclosure (Please select one only):
□ Treatment Planning □ Other _____

□ **ALLOW VERBAL COORDINATION OF CARE WITH:**
Facility/Provider Name: _____
Phone: _____

Purpose of Disclosure (Please select one only):
□ Coordination of Care □ Other _____

This authorization will remain in effect for one (1) year from date of signature below unless otherwise indicated below:

_____

Authorization: I am aware that this information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule. I understand that I have the right to revoke this authorization by writing, at any time, and sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim. I understand that Springfield Psychological generally may not condition services upon my signing as authorization unless the services are provided to me for the purpose of creating protected health information for disclosure to a third party. **We DO NOT release any confidential medical information which will not be used for treatment.**

_____ _____ _____
Patient Signature Date Date of Birth

_____ _____ _____ _____
Parent/Legal Guardian Name (Print) Parent/Legal Guardian Signature Relationship to Patient Date

_____ _____ _____ _____
Parent/Legal Guardian Name (Print) Parent/Legal Guardian Signature Relationship to Patient Date

***** If there is a court order awarding joint legal custody, both parental signatures are required *****