Springfield Psychological
1489 Baltimore Pike, Suite 250
Springfield, PA. 19064
Phone: (610) 544-2110
FAX: (610) 604-9510

Exton
Havertown
King of Prussia
Philadelphia
North Wales
Sinking Spring
Springfield
West Chester

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):
□ Progress 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 to another provider or facility □ Personal Copy
□ 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 the duration of this episode of care unless otherwise indicated below:
_____

Authorization: I am aware that I can refuse to sign this authorization. I am further 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 in writing, at any time, by sending such written notification to the office address above. I am aware that my revocation will not be effective to the extent that this office 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 legal right to contest a claim. I understand that Springfield Psychological generally may not condition services upon my signing an 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 of Birth	Date

_____	_____	_____	_____
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