Etheridge PSYCHOLOGY
Assessment and Psychotherapy

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AUTHORIZATON TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:		**Date of Birth:**	
Legal Representative name (if patient is a dependent):			

Your **PROTECTED HEALTH INFORMATION (PHI)** includes any individually identifiable health information (e.g., medical records) that is transmitted or maintained in any form (e.g., orally, electronically, by mail).

What are you authorizing?

❒I would like Etheridge Psychology to release my Protected Health Information (PHI) to a person or agency.

❒I would like a person or agency to release my PHI to Etheridge Psychology.

❒I would like Etheridge Psychology and another person/agency to exchange my PHI between them.

Who is the other person or agency you are authorizing?

Name/Agency:	**Phone:**
Address:	**Fax:**

How may we release your Protected Health Information? Check all that apply.

❒ Mail via USPS postal mail ❒ Oral communication ❒ By fax ❒ By email*

***Email is not considered to be a secure form of communication.**

Which date(s) of service are you authorizing disclosure of Protected Health Information?

Date(s) of service:

What specific Protected Health Information are you authorizing to be released?

❒ Psychological Evaluation Report	❒ Psychiatric Records	❒ Psychotherapy records (may include psychotherapy notes or treatment summary)
❒ Medical Records	❒ Other (please specify):	

Why are you authorizing the disclosure of the specified Protected Health Information?

❒Continuation of health care ❒Legal purposes ❒Personal use

❒Other (please specify):

I understand the following:

- The information disclosed may include sensitive information relating to mental health and may contain information regarding sexual abuse/assault, drug/alcohol use, HIV/AIDS and other communicable diseases, and genetic testing that has been disclosed to Etheridge Psychology.
- I have the right to inspect or copy the PHI that is used or disclosed and that I must make a request to inspect or copy the information from the provider who is disclosing the information, not the provider receiving the information.
- I may cancel this authorization at any time in writing to Etheridge Psychology. Revocation of this authorization will not affect any disclosures of PHI made prior to revocation of this authorization.
- Once my PHI is disclosed, it may be re-disclosed by the recipient of the information who may not be bound by the same privacy laws governing the practice of psychology.
- I understand I am not required to sign this authorization, my treatment is not conditioned upon the signing of this document, and I may have any questions regarding this document answered prior to my signature or refusal.
- This authorization will be in effect and valid for one year from the date of signature unless revoked in writing or unless a specified date of revocation/expiration is listed here (list alternate expiration date if desired):

Signed:	**Date:**

*If you are signing this form as the Legal Representative of the patient, your signature indicates that you are affirming that you have the legal authority to independently act on the patient's behalf to access or authorize the release of the patient's Protected Health Information.