Blackstone Valley Family Therapy, Ltd

Authorization Form for Releasing/Obtaining Protected Health Information

This form when completed and signed by you, authorizes me to release and/or obtain protected health information with the person you designate.

I authorize my David W. Ingle, Psy.D., and/or his administrative and clinical staff

to release/obtain:

______ All mental health records
______ Initial evaluation
______ Progress notes
______ Treatment plan
______ Lab work
______ Any necessary information to coordinate care with other health care providers
______ Other Information: ____

for dates of service:

______ All
______ Specific dates: _________________________________

with the method of communication being:

______ Telephone/Verbal/Email
______ Photocopies/Fax machine

I am requesting my psychotherapist to release/obtain this information for the following reasons ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose):

______ Patient care
______ At the request of the individual
______ Other: ____

This information should only be released to/obtained from (name, address and phone number of professional or agency):

____

____

____.

This authorization shall remain in effect until (fill in expiration date): _____________________
or until (fill in an event that relates to the individual or the purpose of the use or disclosure)____________________________
____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I 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 a legal right to contest a claim.

I understand that my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to additional disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Please print and sign your name below:

Signature: ____________________________________ Date: ___________________________

Printed Name: ____________________________________

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided: ____