Authorization to Release/Obtain Information

Patient:
Address:
Phone:
DOB:
Treating Clinician:
127 South 5th St, Suite 100, Quakertown, PA 18951 215-536-2790

Release to:
Address:
Phone/Fax:

I authorize the clinician to release/obtain information related to the following (circle):

Treatment Plan
Pertinent treatment information
Medical Information
Other (reason stated below)
Evaluation Results
Copy of Treatment records
Consultation

The purpose of this release is for the following reasons (circle):

Consistency of Treatment
Referral
Personal Request of Patient
Other (state reason below)
Billing/Insurance
Legal Representation
Education

Authorization will remain in effect from ___________ until _________. This will automatically expire after 90 days from signing date.

I understand that I have the right to revoke this authorization at any time by sending such written notification to the clinician's office address. My authorization will not be effective to the extent that the clinician has taken action in reliance on my authorization, or, if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim. I understand that the clinician generally may not condition psychological services upon my signing the authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Private Policy.

Signature of Patient (if 14 years of age or older)

Signature of parent/guardian (only if under the age of 14)

Date