

Medical & Rehabilitation Psychology Associates, Inc.

Authorization to Furnish or Release Medical &/or Psychological Information

This form, when completed and signed by you, authorizes this practice to release protected information from your clinical record to the person you designate.

I, _____ (Patient Name), authorize Medical & Rehabilitation Psychology Associates, Inc., their administrative and clinical staff to release and/or obtain a complete copy of medical/psychological information contained in my clinical record beginning with the first date of service and any parts thereof to the person(s) listed below.

This release of information is requested for the continuance of medical/psychological care and shall remain in effect for one year from the date of signature.

Release/Obtain Records:

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Family Member/Spouse: _____ Phone: _____

Neurologist: _____ Phone: _____

Attorney/Counsel: _____ Phone: _____

Other(s): _____ Phone: _____

Other(s): _____ Phone: _____

The patient has the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, the revocation will not be effective to the extent that we have acted 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.

As the patient, I understand that the psychologist 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.

As the patient, I also understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPPA Privacy Rule.

Printed Name of Patient

Date of Birth

Signature of Patient/Guardian (Relationship to Patient)

Date

Signature of Witness

Date