Western Reserve Psychological Associates, Inc.

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Telephone: 440-526-2208

Authorization Form

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

I, ______________________________________ (_________________), authorize _____________________________________
(Patient's printed name) (Patient's date of birth) (Psychologist's Name)

at Western Reserve Psychological Associates, Inc. and/or his or her administrative and clinical staff:

- ❑ To ***disclose*** protected health information to the individual named below
- ❑ To ***obtain*** protected health information from the individual named below
- ❑ To ***exchange*** protected health information with the individual named below

Name of Individual____ Phone: ______________________

Address____Fax: ________________________

City, State, Zip ____

Dates of service to release (From)**:**______________________________ (To)**:**___________________________________

Type of Information to be Disclosed/Obtained/Exchanged:

❑ Treatment Summary ❑ Psychological Testing Results ❑ Medication(s) ❑ School/Education Records
❑ Diagnosis ❑ Appointments Kept ❑ Hospital Records ❑ Alcohol/Substance Use

❑ Other____
(Provide a description of the information to be disclosed. The description should be specific and detailed.)

This authorization does not include permission to release Psychotherapy Notes. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record. Release of Psychotherapy Notes requires a separate authorization.

Purpose of Release:____
Please specify – (e.g., coordination of treatment, legal, personal use)
"At the request of the individual" is sufficient

Release Format(s): ❑ Verbal Communication ❑ Written ❑ Electronic Media (Fax)

Expiration Date: __________________________________ or until ____
(1 year from date signed below) (specify event or another date)

I have the right to revoke this authorization in writing at any time by sending such written notification to the office address. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

I understand that my 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. I have the right to copy and to inspect the information disclosed and have the right to receive the practitioner's Notice of Privacy Information Form.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and may no longer be protected by law. There may be a charge for the service of releasing/copying medical information as allowed by law. There is no charge to send records directly to my health care provider.

I have read and understand the above information and give my authorization voluntarily.

____ ____
Signature of Patient/Patient's Personal Representative Printed Name Date

_______________________________________ ____
Relationship, if not Patient Witness signature Date

Revised 08-21-2018