CA PSYCHOLOGY

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____ , hereby voluntarily authorize the disclosure of information from my health records.

The information is to be disclosed by:

____
Name of Person/ Organization/ Facility

____
Address

____
City/ State

And is to be provided to:

____
Name of Person/ Organization/ Facility

____
Address

____
City/ State

For the Purpose of:
(Please initial next to appropriate box)

____ Coordination of Care
____ Personal Use
____ Other (*Specify*):
_____ Legal Purposes
_____ Insurance
_____ Administrative
_____ School

The information to be disclosed from my health record:
(Please initial next to appropriate box)

_____ Only Information related to (*specify*) :____
_____ Only the period of event from: __________________________ to: __________________________
_____ Other (*specify*): ____
_____ Entire record

Unless otherwise revoked, this authorization will expire on the following date or event ______________. If a date or event is not specified, this authorization will expire **one year** from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and CA Psychology, LLC will not condition my treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for (1) research related treatment, or (2) health care provided solely for disclosure to a third party, or 3) health plan initial enrollment/ eligibility determination, underwriting, or risk rating determination.

I understand that I may revoke this authorization at any time by notifying CA Psychology, LLC, in writing, of my revocation. I understand that the revocation will not apply to any information that was already released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipients and may no longer be protected under federal privacy regulation.

I hereby release CA Psychology, LLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by CA Psychology, LLC.

______________________________	______________________________
Patient Name (printed)	Clinical Psychologist Signature
______________________________	
Patient Signature	
______________________________	______________________________
Date	Date