216 North Michigan Avenue, League City, Texas 77573-2431 | www.psychology-resources.com | Phone: 281-332-5100 | Fax: 281-332-5155

AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL RECORDS AND INFORMATION

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form. Any duplication, transmittal, re-disclosure, or re-transfer of information is expressly prohibited. This is a two-way release meaning information can be exchanged as needed between Psychology Resources and the indicated person or facility listed below on a limited basis as indicated in this document.

I, _____authorize Psychology Resources, whose main office is 216 N. Michigan Ave, League City, Texas, to release/exchange by phone, fax, email or mail the PHI from the client record(s) of

_____ _____

Last First Middle Date of Birth

With:

Person or facility: _____

Mailing Address: _____ Phone: _____

_____ Fax: _____

Email Address: _____

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations.

I, the undersigned, understand that a copy of this signed authorization form is as acceptable as the original.

The protected health information to be disclosed includes those selected below:

_____ Any and All information/records
_____ Treatment Planning Notes
_____ Progress & Treatment Notes
_____ Reason for Termination
_____ Assessment Information
_____ Results/Reports of Psychological Testing
_____ Recommendations

_____ Scheduling/Canceling Appointments
_____ Financial/Billing Information

Other (please specify): _____

_____

For the purpose of: (Circle all that apply.)

Continued Care; Education; Legal; Insurance; Collaboration; Other: (Please specify) _____

These records concern the time between: (Check one below.)

_____ All and Future

_____ _____ and _____

This release will expire: (Check one below.)

_____ at the end of 120 days
_____ at the termination of treatment
_____ as of _____

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that I may revoke this authorization at any time. I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

_____ _____ _____

Client Signature Printed Name Date

_____ _____ _____

Parent/Guardian/Legal Representative Signature Printed Name Date