LINDA BERLIN, PSY.D.
&
PSYCHOLOGICAL ASSOCIATES

AUTHORIZATION FOR RELEASE AND/OR RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

Last Name: ________________________First Name: ____________________ Middle Initial: _________

Date of Birth: Month: _____ Day: _____ Year: _____ Social Security #: _____________________

Legal Guardian's Last Name: _________________ Legal Guardian's First Name: __________________

Phone number: ___________________ Fax number and/or E-mail: ______________________________

I hereby authorize the use and/or disclose of my individually identifiable health information as indicated below. I understand that this authorization is voluntary and that if the entities authorized to share the information are not health plans or health providers, then the shared information may not longer be protected by federal privacy regulations.

Entity or individual **sending** information:

Name: _______________________________________

Street Address: ________________________________

City:________________State: _____ Zip code: ________

Phone:__________________Fax: __________________

Entity or individual **receiving** information:

Name: _______________________________________

Street Address: ________________________________

City:________________State: _____ Zip code: ________

Phone:__________________Fax: __________________

INFORMATION TO BE DISCLOSED (*Check the appropriate lines and include other information where indicated*):

___ Neuropsychological/ Psychological evaluations and/or consultations

___ Comprehensive Medical Record

___ Summary Health Information: (includes Discharge Summaries, History and Physical, radiology, Pathology, Laboratory, Nursing and Operative reports/dictated notes)

___ Demographics and History

___ Clinical Therapy evaluations and progress notes/reports (Occupational, Speech and/or Physical Therapies)

___ Information relating to psychiatric and/or psychological diagnosis symptoms, prognosis, and treatment

___ Information related to treatment of alcohol and/or drug abuse

___ Other: ____

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:

___ Sharing with health care providers

___ Insurance use

___ Legal use

___ Family members, friends, etc.

___ Other: ____

I request that the following information not be shared: ____________________________________

I understand and agree to the following (Please read and initial the statement below):

___ I have the right to revoke this authorization in writing unless Medical Records (PHI) has already been release or if otherwise prohibited by state or federal law.

___ I have the right under the Federal Protected health Information regulations to make amendments where appropriate.

___ I understand that my health information may be subjected to re-disclosure by the recipient and not protected by federal and/or state privacy laws.

___ I understand that the authorizing of the disclosure of information identified above is voluntary and this Authorization is not intended to alter receiving healthcare and treatment services from any health care provider or payment for your healthcare.

___ I understand that I may see and copy the information described on this form if I ask for it and get a signed copy.

This information will expire on the following date or event: ____

THIS AUTHORIZIATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED, UNLESS OTHERWISE INDICATED.

____ _____________________________________

Patient's signature Date

____ _____________________________________

Legal Guardian signature, if applicable Date

____ _____________________________________

Linda Berlin, Psy. D. Psychological Associates, PA Date

State of __________________________

County of ________________________

The foregoing instrument was acknowledged before me this ______ day of ___________, _________
by ____.

____

Print name: _________________________________

Commission expires: ___________________________

Personally known _____________ or

Produced identification ________________________ Type of identification: _________________________