Hope and Inspiration Psychological Services, PLLC
16501 D Northcross Drive   Huntersville, NC 28078

Phone: 704-325-9464 Fax: 704-275-1833

Patient Name:______________________________

Patient DOB: ______________________________

Medicaid #:______________________________

Request and Authorization Form for the Release of Health Information

This form when completed and signed by you authorizes us to release, receive, or exchange protected information from your clinical record to/from the person you designate.

I authorize **Hope and Inspiration Psychological Services** to ☐ **exchange** ☐ release ☐ obtain protected information.

This data shall include:

☐ pertinent progress notes	☐ intake summary
☐ attendance records	☐ treatment recommendations
☐ Substance Abuse (Statute 42CFR Part2)	☐ HIV/AIDS Status (statute G,S. 130A-143)
☐ medication records	☐ medical records
☐ **psychological test report**	☐ bill for services
☐ discharge summary	☐ other _______________

This information should only be ☐ **released to** and/or ☐ released from

Name: ____

Address: ____

City, State, and Zip ____

Phone/Fax: ____

I am requesting **Hope and Inspiration Psychological Services** to release this information for:

Specific Purpose: ☐ to aid in treatment planning ☐ **at the patient's request**
☐ to aid in evaluation ☐ other:_______________

This authorization shall remain in effect for **<u>1 year</u>** or until (fill in the date or an event that relates to the individual or the purpose of the use or disclosure)

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action 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.

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 understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

☐ I do not want information related to my HIV/AIDS status or information related to substance abuse to be released to a third party.

______________________________ ______________________________ _______________

Signature of Patient **Parent/Representative** **Date**