Authorization for Release of Protected Health Information

Patient Name: ____________________________________

Date of Birth (MM/DD/YYYY): _____ / _____ / ________

I authorized Primary Psychology of Central Florida, LLC to obtain and/or release medical, psychiatric, alcohol and/or drug abuse, psychological assessments, and/or any other records or sensitive nature from/to:

Name of Individual, Hospital or Agency:

____

Address:____

Telephone: ______________________________ **Fax Number**: ____________________________

For the purpose of:

____

("all the request of the individual" is all that required if you are my patient and you do not desire to state a specific purpose)

Specific information to be released:

____

This authorization shall remain in effect until __________ or until ________________________

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 no be effective to the extent that I have acted in reliance on the authorization on if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has 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 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.

________________________________ ______________________________ ____________________

Signature of Patient or Parent/Guardian | Relationship to Patient (if applicable) | Date