Primary Psychology of Central Florida, LLC

Psychological Services for Family Well-Being
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Authorization for Release of Records

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person or entity you designate.

I, _____, authorize
_____
(Patient or Parent/Guardian Name) (name of doctor or entity possessing clinical records)

and/or his or her administrative and clinical staff to release _____,
(provide description of the information that you want disclosed. Your description should be as specific and detailed as possible)

in regards to the patient, _____, for the following reason(s):
(Patient Name)

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

This information should only be released to (name and address of person to whom the information is to be released)

_____ _____
(name) (address)

This authorization shall remain in effect until _____ or until _____
(fill in expiration date) (fill in 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.

_____ _____ _____
Signature of Patient or Parent/Guardian Date Patient Date of Birth

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.