NANCY IREY HOLMES, PSY D

Licensed Psychologist

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Authorization to Disclose Protected Health Information

(This authorization must be written, signed & dated by the client or by a person allowed by law to give consent.)

CLIENT NAME: ____ DOB: ________________

I authorize Nancy Irey Holmes, Psy.D. to: _______ **Obtain protected information from:**
and/or
________ **Provide protected information to:**

Clinician/Facility/Insurance Name: _________________________________ Phone: ________________

Address:____
Address City State Zip

Service or Care They Provide(d): ____

By ***initialing*** each relevant space below I specifically authorize the information to be used on my behalf for the following purposes:

_______ Treatment Planning _______ Insurance/Quality Assurance/Utillization Review
_______ Coordination of Care _______ At the Request of the Individual
_______ Continuity of Care _______ Other:_________________________________

By ***initialing*** the relevant spaces below I specifically authorize the release of the following mental health and/or medical records if such records exist:

_____ Intake Summary & Treatment Plan
_____ Most Recent 5 Year History
_____ Psychological Testing Reports
_____ Clinicians Psychotherapy Notes*
_____ Verbal or Written Summary of Treatment w/Diagnoses
_____ Medical or Hospital Records Needed for Continuity of Care
_____ Drug/Alcohol Diagnosis, Treatment or Referral Information*** Specify:______________________
_____ Consultations
_____ Clinical Record
_____ School Records
____HIV/Aids Related Records**
_____ ER/Urgent Care Notes

____

_____ Other: ____

_____ Please send entire medical records to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this info.

*****Must*** be initialed in order to be disclosed. ******HIV/Aids information must be initialed to be included in other documents. *******Federal Regulation 42, CFR Part 2 requires a description of how much and what kind of drug information is to be disclosed.

_____ This authorization is limited to the following time period: _________________________________

_____ This authorization is limited to the following treatment: __________________________________

_____ This authorization is limited to a Worker's Compensation Claim for injuries on: _______________
Date

I understand that my psychologist 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.

This authorization may be revoked in writing at any time. The only exception is when action has been taken in reliance on the authorization (see Notice). Unless revoked earlier, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

This authorization is in effect until _________ or until ____.
Date Event that relates to Person or Purpose

I have carefully read and understand this authorization for release of protected mental health and medical records and I voluntarily authorize disclosure of these specified records for the purposes stated above. Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPPA privacy rule.

____ __________________
Signature of Client Date

____ __________________
Signature of Person Authorized by Law Date

Revoked: _______________________________________ __________________
Signature Date