

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**AUTHORIZATION FOR RELEASE**

\_\_\_\_\_**(Initials)** **AUTHORIZATION FOR RELEASING CONFIDENTIAL PSYCHOLOGICAL RECORDS AND PROTECTED HEALTH INFORMATION TO and FROM OUTSIDE AGENCIES OR INDIVIDUALS:**

This form when completed and signed by you, authorizes us to release protected information from your clinical record by mail, facsimile, email or personal communication to the person or agencies you designate AND authorizes outside agencies or individuals to release protected information to Ascend Psychology/Dr. Yudell & Associates.

This information may be released or received by sending copies, facsimile, email, mail, by phone or in person and should only be released to / from (NAME, METHOD OF CONTACT (phone / email) and ADDRESS of person(s) or agencies to whom the information is to be released)

**Person(s) / Agency:** \_\_\_\_\_

**Phone # & Email address:** \_\_\_\_\_

**Address:** \_\_\_\_\_

This authorization shall remain in effect until 120 days following the termination of therapy or closure of my case or file.

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

By signing below, you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. You are indicating that you understand that Ascend Psychology/Dr. Yudell & Associates 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 redisclosure by the recipient of your information, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

**Name** \_\_\_\_\_

**Signature of Patient / Authorized Representative** \_\_\_\_\_

**Date** \_\_\_\_\_

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.

**ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED:**

If you have received this information in error, please contact our office as soon as possible to arrange for the return of the received material. The information you have been seen may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed by law.