CRESTVIEW
Psychological Testing & Counseling Center

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CRESTVIEW PSYCHOLOGICAL TESTING & COUNSELING CENTER
RELEASE OF INFORMATION

I, _____ (Patient), whose Date of Birth is_____,

authorize [Crestview Psychological Testing & Counseling Center] to disclose to and/or obtain from:

_____ the following information:
(Name of Person or Organization)

Description of Information to be Disclosed (initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Nursing/Medical Information
_____ Medication Management Information
_____ Presence/Participation in Treatment

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)

_____Other_____
_____Other_____

PURPOSE
This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:
_____
_____
_____
_____

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REVOCATION
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Crestview Psychological Testing & Counseling Center. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

EXPIRATION
Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

CONDITIONS
I further understand that Crestview will not condition my treatment on whether I give authorization for the requested disclosure.

FORM OF DISCLOSURE
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

RE-DISCLOSURE
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient refuses to sign authorization