Kortanek Psychological Services, Inc.

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Authorization to Release Protected Health Information

(HIPAA-Compliant Form, Pursuant to 45 CFR 164.508)

Patient Name: _____

Name of person completing this form: _____

Relationship between person completing this form and the patient: _____

I authorize _____ (healthcare provider) to (check all that apply)

- o Disclose the above named patient's protected health information to:
- o Received the above named patient's protected health information from:

Name: _____

Contact Information: _____

In signing this form I am limiting authorization to include the release of only the following information (check all that apply):

- o Information from only the following dates: _____
  (write in limited dates or write "All Dates")
- o Mental health evaluation information
- o Mental healthcare progress notes (summarizing each session)
- o Mental healthcare psychotherapy notes (detailing discussions in session)
- o Treatment Summary reports
- o Educational records
- o Medical records
- o Correspondence (such as letters, emails) with persons other than healthcare providers or educators
- o Communicable diseases information (including HIV and AIDS)
- o Alcohol/Drug abuse treatment information
- o Other: _____

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I understand that I am authorizing the release of protected health information of (patient name) _____ for the following purpose (check all that apply):

- o To facilitate coordination or continuity of care from multiple service providers
- o To inform family or other individuals who provide non-professional support
- o To help in resolving insurance claims and health benefit coverage issues
- o To satisfy requirements from a third-party (such as school, employer, law enforcement)
- o Other: _____

I understand that the recipient of my information might not have the same legal requirement of confidentiality that governs my healthcare provider. By authorizing my healthcare provider to release my information, I acknowledge that my healthcare provider cannot prevent further release of my information by the person who receives my information.

I understand that my authorization to release my protected health information is voluntary and that I may refuse to sign this authorization

I understand that I may revoke this authorization at any time by providing notice in writing. I understand that revocation of the authorization cannot apply to any information already sent to the designated recipient while the release was in effect (before authorization was revoked). If I do not revoke this authorization in writing, this authorization will expire on the following date:_____

Signature of Patient (or Legal Representative); _____

Name of Patient (or Legal Representative): _____

Date: _____