Grelling Psychology Associates

sensitive, professional care for individuals and families

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RELEASE OF PROTECTED HEALTH INFORMATION - AUTHORIZATION FORM

Name of Patient: ________________________________Birthdate: __________

I authorize my/my child's therapist, ____________________________, to release my/my child's protected health information ("PHI"), for the purposes acknowledged below.

This information should only be released to:

Name:____

Contact Information: ____

____

Name:____

Contact Information: ____

____

Name:____

Contact Information: ____

____

Name:____

Contact Information: ____

____

Purpose of this disclosure (check one):

☐ To facilitate treatment and/or evaluation of myself or my family member

☐ Other ____
(Provide a reason for the disclosure)

(Continued on Second Page)

RELEASE OF PHI AUTHORIZATION FORM- PAGE 2

This authorization shall remain in effect until (check one):

☐ Treatment has been terminated

☐ Date : _______________

☐ Event: ____
(fill in an event that relates to the individual or the purpose of the use or disclosure)

After this expiration my therapist can no longer use or disclose my protected health information without first obtaining a new authorization form.

I understand that my therapist generally may not condition receipt of services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification. However, I also understand that this revocation will not be effective to the extent that my therapist has 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 information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

I fully understand the terms of this authorization.

____ __________________
Signature of Patient or Personal Representative Date

____
Printed Name

____
Personal Representative’s authority if appropriate (e.g. “Parent” or “Guardian”)