Catherine Kaplan, Ph.D., LLC
Licensed Clinical Psychologist

HIPAA Compliant Authorization
For the release of Patient Informaiton Pursuant to 45CFR 164.508

TO:

_____
Name of Healthcare Provider/Facility

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Fax

RE: Patient Name: _____

Date of Birth: _____Social Security #: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

____ All medical records from _____ to _____ meaning every page in my record, including but not limited to: office notes, consultation notes, all clinical charts, reports, progress notes, social worker records, treatment plans, documents, correspondence, test results.

____ All pharmacy/prescription records.

____ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period of _____ to _____.

I understand the information to be released or disclosed maybe include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purpose:

Information may also be in the form of:

____ Letter regarding _____

____ Verbal report regarding _____

This authorization is given in compliance with the federal consent requirements for the release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following who have agreed to pay reasonable charges made by you to supply copies of such records:

Name

Relationship to Patient

Street Address

City, State, Zip Code

Telephone Fax

I understand the following: See CFR 164.508(c)(2)(i-iii)

A. I have the right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization.
B. The information released in response to this authorization may be re-disclosed to other parties.
C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative Date

Name and Relationship of Legally Authorized Representative to Patient

Witness Signature Date