AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (BPA)

Printed Patient Name:	Date of Birth:
Address:	Telephone Number: (_____)_____
City: _____ State: _____ Zip Code:_____	

I hereby authorize Behavioral Psychology Associates, P.C. to release and exchange written, oral or electronically transmitted protected health information indicated below on the above named individual to:

_____
Provider Name/Organization/Individual

_____
Address of Provider/Organization/Individual

Fax #: (_____)_____

City: _____ State: _____ Zip Code:_____ Telephone #: (_____)_____

Including information related to: ❒ Mental Health Treatment___ Substance Abuse Treatment___ Medical Treatment___ School ___
❒ Other: _____

For the following purpose: ❒ Physician or Health Care Facility Use___ Legal Use___ Personal Use___ Follow-up Care___
❒ School/Vocational Placement___ Insurance Determination___ Continuity of Care___ Other (Specify)_____

Treatment date(s): _____ to _____

Expiration Date: _____
(Should Not Exceed 1 Year)

INFORMATON TO BE DISCLOSED:

Assessment	Treatment/Service		Other
__ Psychiatric	__ Treatment Plan	❒	__ Discharge Summary
__ Psychological	__ Treatment Progress		__ Dates of service
__ Psychological test reports	__ Medication information		__ Lab results
__ Intake	__ Psychiatry Notes		__ Behavior and history of patient
__ Other:	__ Progress Notes	❒	__ Complete copy of clinical record
			__ Other:

❒ **HIV Documentation _____(Must Initial)**

I understand that:

- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to BPA.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.

_____ _____ _____ _____
(Signature of patient) (Date) (Signature of Parent or Legal Representative) (Date)

_____ _____
(Witness Signature) (Date)

(Patients l2 to l7 years of age must sign in addition to the Parent or Legal Representative)
(If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR OFFICE USE: Date received: _____ Date completed: _____
When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: ❒ Driver's License___ Picture ID___ Legal guardian___ ❒ Court appointed legal guardian___ Power of Attorney___ Executor of Estate___ Other:_____

_____
Person completing the request: