QC Psychology
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REQUEST AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FORM

Patient Name:_____ **Date of Birth**:_____

Medicaid #:_____

This form when completed and signed by you authorizes us to release, receive, or exchange protected information from your clinical record to/from the person you designate.

I authorize QC Psychology to ☐exchange ☐release ☐obtain protected information.
This data shall include:

☐ pertinent progress notes
☐ attendance records
☐ substance abuse
☐ medication records
☐ psychological test reports
☐ discharge summary
☐ intake summary
☐ treatment recommendations
☐HIV/AIDS Status
☐ medical records
☐ bill for services
☐ other: _____

This information should only be ☐ released and/or ☐ released from
Name:_____

Address:_____

City/State/Zip Code: _____

Phone/Fax: _____

I am requesting QC Psychology to release this information for the following reasons:
Specific Purpose: ☐ to aid in treatment planning ☐ **at the patient's request**
☐ to aid in evaluation ☐ other:_____
This authorization shall remain in effect for 1 year or until (fill in the date or an event that relates to the individual or the purpose of the use or disclosure)_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on this authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule.

☐I do not want information related to my HIV/AIDS status or information related to substance abuse to be released to a third party.

Signature of Patient:_____ **Date:**_____

Parent/Representative:_____ **Date:**_____