Stone Arch Psychology and Health Services
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Authorization for Release of HIPAA Protected Health Information From Stone Arch Psychology and Health Services To a Designated Person or Organization

By signing this document I am authorizing the release of my HIPAA protected health information specified in Section II from Stone Arch Psychology and Health Services to the person(s) and/or organization named in Section IV.

Section I

Client Full Legal Name _____

Client Date of Birth _____

Section II – Protected Health Information

- ☐ Psychological Report
- ☐ Brief Summary of My Record
- ☐ Progress Report
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Other_____

Section III – Reason for Disclosure

- ☐ Coordination of Treatment Plan
- ☐ Evaluation
- ☐ Court Process
- ☐ Other_____

Section IV – Who Can Receive My Health Information

I give authorization for the HIPAA protected health information detailed in section II of this document to be shared with the following Individual(s) or Organization:

Name(s):_____

Organization:_____

Address:_____

_____

Phone Number:_____

Fax Number:_____

I understand that the person(s) and/or organization listed above may not be covered by state or federal laws governing the privacy and security of HIPAA protected health information and therefore may be permitted to disclose the information that is provided to them by Stone Arch Psychology and Health Services.

Section V – Signature

I understand this release authorizes two-way contact between authorized staff at Stone Arch Psychology and Health Services with the other named individual/organization. This release does not prohibit Stone Arch Psychology and Health Services from communicating in accordance with our HIPAA Privacy Practices Notice and as required by state or federal law. Access will be limited to persons who are authorized to carry out the purposes stated above.

I understand that a photocopy of this release shall be effective for this purpose as the signed original.

I understand that I may revoke this authorization at any time and that this authorization will expire automatically within one year of the date this authorization was signed, or when the purposes for which this authorization was granted are accomplished, whichever occurs first.

_____

Client's Signature Date

_____

Parent/Guardian Signature Date