44 East Main Street
Annville, PA 17003

(717) 966-1388

Annville Psychological Services

Authorization to Use and Disclose Protected Health Information (PHI)

CLIENT NAME:_____ DATE OF BIRTH: _____

I hereby give consent and authorize Annville Psychological Services, to allow the use and sharing of Protected Health Information (PHI) about the above mentioned person to:

_____

Information to be used or disclosed may include: (put an "X" next to each desired)

_____ Referral/treatment summary/update of progress in treatment
_____ Social, family, educational, and vocational history
_____ Academic and educational records
_____ Admission/discharge summary
_____ Psychological evaluation
_____ Treatment plan
_____ Other- list specific items:

This information will be used or disclosed for the following purposes:

_____ Inform referral source of follow-through in treatment
_____ Facilitate continuity of care
_____ Litigation/legal matter concerning client
_____ Other- list specific purpose: _____

I understand and agree that this Authorization will be valid and in effect from the date of signature and will automatically expire one year after the date of signature. I understand that after that date, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer, Kerrie Smedley. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Annville Psychological Services, nor will it affect my eligibility for benefits.

I understand that I may inspect and have a copy of the information described in this authorization.

I have read this form or had it explained to me and I understand its contents.

Client or Guardian Signature and Date: _____

Psychologist Signature and Date: _____