ALABAMA
PSYCHOLOGICAL SERVICES
CENTER

CONFIDENTIAL

AUTHORIZATION FORM

Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information about:

Client's full name: _____ Patient of Doctor: _____

Date of Birth: _____ SSN: _____

Release To: ☐ and / or Obtain From: ☐ _____

Address: _____

Purpose of this authorization: _____

- ☐ Facilitate evaluation or treatment
- ☐ Provide information for insurance purposes
- ☐ Provide information on account charges and payments

Provide information for a legal matter

- ☐ Other (Specify) _____

Treatment Dates to Release: ☐ Any and All Records ☐ Date Range: From: _____ To: _____

Exceptions: _____

Information to be released:

- ☐ Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness.
- ☐ Psychological or psychiatric evaluations(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☐ Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- ☐ Financial information.
- ☐ Other: _____

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to redisclosure by the recipient and no longer be protected by law. APSC is not responsible for any alterations made on its medical record copies, which have been released to any party.

I understand that I have a right to a copy of this authorization after I sign it. I understand that APSC will not condition any provision of treatment on my signing this authorization. This authorization automatically expires in one year from date of signature, and may be revoked at any time. This authorization for **Release of information** is given freely, voluntarily and without coercion.

_____ _____ _____ _____

Signature Date Witness Date

Signature of person authorized to sign in lieu of client: _____

Guardian/Conservator Date

4800 Whitesport Circle Ste 2 – Huntsville, Alabama 35801 – (256) 533-9393 – Fax (256) 533-9690 – apsc@alapsych.com