Clinical Psychology Associates of North Central Florida. P.A.

Mail all Forms to: **Clinical Psychology Associates of North Central Florida, P.A.**
2121 NW 40th Terrace Suite B
Gainesville, FL, 32605
(Phone) 352 - 336-2888

Fax copy to: (352) 371-1730
__(please check) facsimile or copies to be honored as originals.

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AUTHORIZATION FOR CLINICAL PSYCHOLOGY ASSOCIATES OF NORTH CENTRAL FLORIDA, P.A. TO RELEASE CONFIDENTIAL PSYCHOLOGICAL INFORMATION TO OUTSIDE AGENCIES, FACILITIES OR INDIVIDUALS

Name:_____ Date of Birth_____

This form when completed and signed by you, authorizes us to release protected and or confidential psychological information from our clinical record to the person or agencies you designate. You agree and understand that this form does not constitute a general release, and that by checking off or specifying information below you are agreeing to an informed release of specific sensitive and confidential information. You also agree that we are not responsible for and cannot control any further release by the agencies or individuals this information is sent to.

I authorize Clinical Psychology Associates of North Central Florida, P.A. and/or its administrative and clinical staff to release the following individually checked items in their entirety or additional information as indicated below:

____ Intake Summary
____ Discharge/Treatment Summary
____ Treatment Plan
____ History Forms
____ Mental Status Examination
____ Financial Information
____ Ledgers
____ Psychological and Neuropsychological Testing
____ Current and Past Progress Notes
____ Current and Future Progress Notes
____ Participation, Progress and Attendance in Treatment
____ Diagnosis

__ Attendance, Cooperation with Assessment, Establishment and Agreement with Treatment Plan
__ Work Restrictions, Fitness for Duty
__ Letters or updates to referral source or other treating providers
__ Alcohol and/or Drug Abuse Evaluation and Treatment Information
__ Confidential Psychological and Mental Health Information for Treatment Care Coordination
__ Summaries and/or Copies of Records received from outside sources
__ Collateral Interview information regarding_____
_____
__ Accommodations
__ The above are to be released from my EAP records

_____
_____

This information may be released by sending copies, facsimile, by phone or in person and should only be released to (name and address of person(s) or agencies to whom the information is to be released)

_____
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I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____
_____
_____

Unless otherwise specified this authorization shall authorize the release of records from the time I was first seen and will remain in effect until 120 days following the termination of therapy or closure of my case or file.

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

By signing below you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you.

You are indicating that you understand that Clinical Psychology Associates of North Cental Florida, P.A. 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 redisclosure by the recipient of your information, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

___ Records to be released are from the date I was first seen to 120 days after I was last seen or my case closed, whichever is later.

___ Records to be released are from _____ to 120 days after I was last seen/case closed.

___ Records to be released are only from _____ to _____

Name _____ Date of Birth_____

Signature of Patient or Authorized Representative_____ Date _____

Witness_____ Date_____

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED:

If you have received this information in error please contact our office as soon as possible to arrange for the return of the received material. The information you have been seen may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed by law.