BETHEL OLENTANGY PSYCHOLOGICAL SERVICES

STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/ or drug/alcohol treatment, and/or sexual assault.*

AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

SECTION 1

I hereby authorize the disclosure and/or exchange of health information regarding the individual named below
*Please choose the appropriate option(s): Disclose Information: ☐ Exchange Information: ☐

***FIRST NAME**		**M.I.**		***LAST NAME**		***DATE OF BIRTH**	
ADDRESS		**CITY**		**STATE**		**ZIP CODE**	

SECTION 2

Complete the information below for disclosing entity and recipient of the information such as provider, health plan/insurer etc.

***DISCLOSING ENTITY** (The name of your psychologist or provider)			**PHONE**	(614) 451-6606	**FAX**	(614) 451-2923	
ADDRESS	4949 Olentangy River Road	**CITY**	Columbus	**STATE**	OH	**ZIP CODE**	43228
***RECEIVING ENTITY**(The name of the person or business receiving the information)			**PHONE**		**FAX**		
ADDRESS		**CITY**		**STATE**		**ZIP CODE**	

SECTION 3

***Reason for Disclosure** (eg: Financial matters, scheduling, treatment**)**

***Health Information to be Disclosed** (eg: Session dates of service, therapist notes, account balance details, etc)

If applicable indicate treatment date limitations of information below:
Only release information from the period: Date _____ to Date _____

SECTION 4

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. **If no date or event is specified below, this authorization will expire in one year from the document origination date.**

If applicable **Expiration Date or Event** _____

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164].

***SIGNATURE OF INDIVIDUAL**	***DATE**	
***SIGNATURE OF PERSONAL REPRESENTATIVE** *(If Applicable)*	***DATE**	

RELATIONSHIP OF PERSONAL REPRESENTATIVE TO INDIVIDUAL *(Personal representative shall submit proof of authority to the disclosing entity)*

Parent ☐ **Legal Guardian** ☐ **Healthcare Power of Attorney** ☐ **Executor/Administrator** ☐ **Other** ☐ **N/A** ☐

For administrative use only

Method of Deliver _____ Date Release _____