Mail: 15501 San Pablo Ave, G317
Richmond, CA 94806
888-524-5122
www.psychassessment.us

Psychological Assessment Incorporated

Authorization for Release of Information

_____ _____
Member/Patient's Name Date

_____
Member/Patient's SSN & DOB

_____
Street Address City State Zip

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below

I understand that I may revoke this authorization at any time by notifying recipients in writing, but if I do, it will not have any effect on any actions taken before receipt of the revocation**.**

I hereby authorize

_____
_____
_____

to exchange / release / obtain information to/with:

Person/organization receiving/communicating the information:

Name: _____
Psychological Assessment Incorporated

Authorization for Release of Information

Description of individually identifiable health information (initial appropriate type(s) of information) to be released/exchanged/obtained:

____ All Treatment Plan(s)
____ Reports
____ Medical Records
____ Mental Health Records
____ Other (describe): All other pertinent information

The purpose of this release is:
For coordination of continued care

I understand that this authorization will expire**:**

On ____/____/____ (MM/DD/YY),

OR

Once the following event occurs:
_____
_____

(Form must be completed before signing)

_____ _____
Signature of Member/Patient/Legal Guardian or Representative Date

_____
Print Name

The patient or the person signing this form has the right to receive a copy of the Consent Form. A copy of this form has been requested and received:

_____ Yes _____ No **Initials**: _____ (patient)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION