Center for Emotional Health & Wellness, LLC
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Authorization Request for Release of Confidential Health Information Patient Identification

Patient name: _____ Date of Birth: _____ Age: _____
Address: _____
Social Security: _____ Telephone: _____

Authority to Release Protected Health Information: When you complete and sign this form, it authorizes this psychologist to release protected information from your own (or your child's) clinical records to the person or agency below, or to obtain information from this person or agency. You have the right to revoke this authorization, in writing, at any time by sending notification of this revocation to my office address.

I _____, hereby authorize Dr. Richard N. Costa (and/or his staff) to disclose or obtain the following information in regard to the above-named or the above-named minor's psychological/medical/ psychiatric/psychoeducational treatment or evaluation.

Purpose of Requested Disclosure of Protected Health Information: The particular information to be disclose/obtained is the following (please be specific): _____
_____
_____

The information should be disclosed to/obtained from the following (please provide full addresses and telephone numbers):
Name of Agency Provider(s): _____
Address: _____
Phone: _____ Fax: _____ Email: _____

Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting written notice to Dr. Costa. Unless revoked, this authorization will remain in effect until the following date, and/or will expire after the following time period or event: _____

Re-Disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure: I understand the statements above, and I voluntarily consent to disclosing/obtaining this information to/from the person or agency named above. I also understand that I do not have to sign this authorization. However, if health care services are being provided to me for the purpose of providing information to a third party (e.g., fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third party. I can inspect or copy the protected health information to be used or disclosed. I hereby release Dr. Costa (and/or his staff) from any liability that could arise from disclosing or obtaining this information as long as the information is disclosed or obtained in accordance with applicable laws and/or in compliance with this Authorization.

_____ _____
Print Name Today's Date

_____ _____
Signature Date Relationship to Patient

_____ _____
Signature/Assent of Child/Adolescent (If Appropriate) Witness Date

Note: Make 2 Copies. Provide 1 to Patient. Maintain Signed Copy in Patient's File (revised 3/23/12)