Western Reserve Psychological Associates, Inc.

4833 Darrow Road, Suite 101
Stow, Ohio 44224
Telephone: 330-650-5338

Fax: 330-342-3837
www.westernreservepsych.com

7650 Chippewa Road, Suite 306
Brecksville, Ohio 44141
Telephone: 440-526-2208

Authorization Form

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

I, _____ (_____), authorize
(Patient's printed name) (Patient's date of birth)
_____ at Western Reserve Psychological Associates, Inc.
(Psychologist's Name)
and/or his or her administrative and clinical staff:

To ***disclose*** protected health information to the individual named below ❑
To ***obtain*** protected health information from the individual named below ❑
To ***exchange*** protected health information with the individual named below ❑

Name of Individual_____ Phone: _____

Address_____Fax: _____

City, State, Zip _____

Type of Information to be Disclosed/Obtained/Exchanged:

Treatment Summary	❑	Medication(s)	❑
Diagnosis	❑	Alcohol/Substance Use	❑
Psychological Testing Results	❑	School/Education Records	❑
Hospital Records	❑	Appointments Kept	❑

Other _____
(Provide a description of the information to be disclosed. The description should be specific and detailed.)

Purpose of Release: Coordination of Treatment ❑
Other (please specify): *_____
*At the request of the individual is all that is required

Release Format(s)
❑ Verbal Communication
❑ Written
❑ Electronic Media (Fax) for urgent needs only

Expiration Date: _____ or until (event) _____
90 Days (date) (specify event)

You have the right to revoke this authorization in writing at any time by sending such written notification to the 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.

I understand that my psychologist 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 have the right to copy and to inspect the information disclosed and have the right to receive the practitioner's Notice of Privacy Information Form.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and may no longer be protected by the HIPAA Privacy Rule.

I have read and understand the above information and give my authorization voluntarily.

_____ _____
Patient Signature Date

_____ _____
Parent/ Guardian Signature Date

_____
Parent/Guardian (Please Print Name)

Revised 03-04-08