Macks Psychology Group

Dr. Melissa Artnak • Dr. Nicole Bing • Dr. Candace Beck • Dr. Amanda Beeman • Dr. Heather Johnson

Dr. Ryan Macks • Dr. Julie Miller • Dr. Carrie Piazza-Waggoner • Dr. Alexis Pittenger • Ms. Christy Pulsford

Authorization for Disclosure of Health Information and Records

Name of Patient: _____ DOB: _____

Person or Facility: _____

Address: _____

Phone: _____ Fax: _____

__ I hereby authorize the above named person or facility to release the following information to my provider at the Macks Psychology Group:

__ School records (ETR, IEP, 504, etc)

__ Developmental & social history

__ Psychological/speech evaluation reports

__ Progress notes/treatment summary

__ Medical history & evaluations

__ Other: _____

__ I hereby authorize my provider with the Macks Psychology Group to disclose information about the above-named patient's psychological or speech testing results or treatment services to the above named person or facility. This information may include any evaluation report, diagnostic interview notes, progress/therapy notes, treatment plan, or termination summary.

I fully understand this request/authorization for release of records between my provider and the above named person or facility. I understand that this authorization is effective immediately and will remain in effect for the duration of the professional relationship for professional services between by my provider and the above named patient, and for up to 365 days after termination of this relationship. I understand that I have the right to revoke this authorization at any time by submitting a request in writing to my provider.

I understand that I may refuse to sign this authorization, and that my provider may not condition my treatment upon whether I do so. I understand that if I authorize the disclosure of information to someone who is not legally required to maintain confidentiality, the recipient may re-disclose it, and it may no longer be protected. I understand that I have the right to inspect or copy the protected health information to be used or disclosed.

By signing below, I indicate that I have read the Authorization for Disclosure of Health Information and Records, and offer my consent to disclose those records indicated above.

_____ _____ _____

Patient or Parent/Guardian Signature | Relationship to patient | Date

_____ _____

Witness/MPG Provider or Administrator Signature | Date

7799 Joan Drive West Chester, Ohio 45069 • Phone: (513) 204-5746 • Fax: (513) 229-3707

contact@mackspsychology.com • www.mackspsychology.com