GODMAN PSYCHOLOGICAL SERVICES, P.C.
Helping to navigate the mind
4231 Balboa Avenue #1256
San Diego, CA 92117
T: (619) 785-3665
info@godmanpsych.com

Healthcare Release of Information Form

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Email: _____

I, the undersigned, authorize Godman Psychological Services, PC to:

☐ Release information to ☐ Obtain information from

Recipient's Information:

- Name/Organization: _____
- Relationship to Patient: _____
- Address: _____
- Phone Number: _____
- Fax Number (if applicable): _____
- Email: _____

This authorization will expire on: _____ (if no date is provided, authorization will expire one year from the date of signing).

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Specific Information to be Released (Check all that apply):

☐ Diagnosis and Treatment Summary
☐ Psychological Evaluation Reports
☐ Therapy Progress Notes
☐ Treatment Plan
☐ Medication and Prescribing Information
☐ Session Attendance Records
☐ Billing and Insurance Information
☐ Other (please specify): _____

Purpose of Disclosure:

☐ Coordination of Care
☐ Insurance/Billing Purposes
☐ Legal Proceedings
☐ Personal Request
☐ Other (please specify): _____

Method of Information Sharing (Check all that apply):

☐ Verbal Communication
☐ Printed Records
☐ Electronic Communication (Email/Fax)
☐ Other (please specify): _____

Confidentiality & Patient Rights: I understand that:

The above information will be used for continuity of care or emergency purposes.

I understand that this information may be protected by Title 45 of the Code of Federal Regulations, Security and Privacy, Part 164, and Title 42 of the Code of Federal Regulations of Confidentiality of Substance Use Disorder Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that I relinquish, give up, and waive these provisions of law and privileges relating solely to the disclosure specifically authorized by me for these documents. All

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other rights, privileges and provisions of law are resumed. I further understand that this Authorization may be released electronically, and subject to redisclosure by the recipient if they are not a health care provider and might no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA").

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice to the above referenced entity, except to the extent that action has been taken in reliance on this authorization. After one year, this consent automatically expires.

I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization and there may be a reasonable fee to obtain a copy of the information requested on this form.

I understand that I have a right to refuse to sign this authorization, and the above entity may not withhold or condition treatment, payment, enrollment or eligibility for benefits upon receipt of this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Patient Authorization: I have read and understand the above information and authorize the release of my health information as indicated.

Patient Signature: _____ **Date:** _____

Guardian/Representative Signature (if applicable): _____
Relationship to Patient: _____

For Office Use Only:

- Date Request Received: _____
- Processed By: _____
- Date Information Released: _____