Lisa Robinson, Ph.D.
AGCR Psychological Services, LLC
P.O. Box 84224
Pearland, TX 77584
(Tel.) 713-922-5339
(Fax) 713-433-9997

____
Patient Name

____
Date of Birth

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION FORM

I, ___________________________________, hereby authorize Dr. Lisa Robinson and/or his or her administrative and clinical staff to OBTAIN or DISCLOSE the following information:

____Confirmation of participation in therapy
____Treatment progress
____Assessment/Psychological testing results
____Treatment summary
____Summary of evaluation findings

____Mental health records
____Records related to drug and or alcohol use/treatment
____Records related to HIV-status
____Medical health records (case notes, written reports, contact notes)
____On-going consultation
Other: ____

Restrictions: None _____ As indicated: ____

This information is to be released for purpose of: psychological evaluation______, treatment planning ______, treatment coordination/consultation ______, other ____

This authorization shall remain in effect until (give date or event): (end of treatment episode)_____, (6 months) _____, (1 year) _____, other____. If left blank, this authorization shall expire one year after date signed below.

This information should only be released to or obtained from:

____
Name

____
Phone

____
Fax

____
Address

____

- You have the right to revoke this authorization, at any time by written notification. However, your revocation will not be effective to the extent that your clinician has 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 clinician 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 understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and may no longer protected by the HIPAA Privacy Rule.

____ I AUTHORIZE the release of any records that have been obtained by Dr. Robinson from other providers

____ I DO NOT AUTHORIZE the release of any records, in Dr. Robinson's possession, that have been obtained from other providers.

__________________________/___________________________________
Signature of Patient, Legal Guardian, Authorized Representative of Patient

____
Date

Relationship to patient: Self _____ Parent _____ Other ___________________________________

Notice to receiving agency or person: This information has been disclosed to you from records whose confidentially is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminal investigate or prosecute any alcohol or drug abuse clients.

Revised 9/1/18