



Lisa Robinson, Ph.D.
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 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:

- | | |
|--|---|
| <input type="checkbox"/> Confirmation of participation in therapy
<input type="checkbox"/> Treatment progress
<input type="checkbox"/> Assessment/Psychological testing results
<input type="checkbox"/> Treatment summary
<input type="checkbox"/> Summary of evaluation findings | <input type="checkbox"/> Mental health records
<input type="checkbox"/> Records related to drug and or alcohol use/treatment
<input type="checkbox"/> Records related to HIV-status
<input type="checkbox"/> Medical health records (case notes, written reports, contact notes)
<input type="checkbox"/> 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	Address
Phone	
Fax	

- 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 be 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 confidentiality 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.