DIVERSE ASSESSMENTS & TREATMENT, LLC

TODD M. SIGLER, PSYD, LP, NCC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This form when completed and signed by you, authorizes *Todd M. Sigler, PsyD, LP, NCC* to release protected health information (*PHI*) from your clinical/therapy/psychological evaluation/consultation record to the person/agency you designate.

I, _____, DOB: _____, authorize *Todd M. Sigler, PsyD, LP, NCC* to **RELEASE/ EXCHANGE**:

- ☐ Educational Issues
- ☐ Social History Reports
- ☐ Physical Examinations
- ☐ Psychological Test Interpretation
- ☐ Treatment Plan(s)
- ☐ Health & Behavior Assessment
- ☐ USCIS Forms & documents
- ☐ Psychiatric/Psychological Evaluation
- ☐ Medication History
- ☐ Discharge Summary
- ☐ Treatment for Drug &/or Alcohol Abuse
- ☐ Billing Information
- ☐ IEP/Evaluation Reports/Academic Assessments
- ☐ Scheduling, Coordination

with: _____

_____

_____

The information is being released for the following reasons "*AT THE REQUEST OF THE INDIVIDUAL*." This ARI will remain in effect for **ONE YEAR** of date signed or until ____/____/_____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I 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 Todd M. Sigler, PsyD, LP, NCC generally may not condition mental health services upon my signing an authorization unless mental health 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 no longer protected by the HIPAA Privacy Rule.

_____ _____ _____

Patient/Personal Representative Signature **Relationship to the Patient** **Date**

(If authorization is signed by a personal representative of the patient, a descriptor of such representative's authority to act for the client must be provided, e.g., "parent", "guardian", etc.)

_____ _____

TODD M. SIGLER, PSYD, LP, NCC **Date**

A COPY OF THIS AUTHORIZATION FORM SHALL BE AS VALID AS THE ORIGINAL

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