



TODD M. SIGLER, PSYD, LP, NCC

AUTHORIZATION TO RELEASE (ARI) 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 *Dr. Sigler* to **RELEASE/ EXCHANGE:**

- | | |
|-----------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Educational Issues | <input checked="" type="checkbox"/> Psychiatric/Psychological Evaluation |
| <input checked="" type="checkbox"/> Social History Reports | <input checked="" type="checkbox"/> Medication History |
| <input checked="" type="checkbox"/> Physical Examinations | <input checked="" type="checkbox"/> Discharge Summary |
| <input checked="" type="checkbox"/> Psychological Test Interpretation | <input checked="" type="checkbox"/> Treatment for Drug &/or Alcohol Abuse |
| <input checked="" type="checkbox"/> Treatment Plan(s) | <input checked="" type="checkbox"/> Billing Information |
| <input checked="" type="checkbox"/> Health & Behavior Assessment | <input checked="" type="checkbox"/> IEP/Evaluation Reports/Academic Assessments |
| <input type="checkbox"/> USCIS forms & communications | <input type="checkbox"/> _____ |

RELEASED/EXCHANGED with: _____

Fax #: _____ - _____ - _____ Office#: _____ - _____ - _____ Email: _____

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.

_____ <i>Patient/Personal Representative Signature</i> <small>(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.)</small>	_____ <i>Relationship to the Patient</i>	___/___/___ <i>Date</i>
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_____ <i>Todd M. Sigler, PsyD, LP, NCC</i>	___/___/___ <i>Date</i>
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A COPY OF THIS AUTHORIZATION FORM SHALL BE AS VALID AS THE ORIGINAL