Taylor Psychological Services, PC
1300 W. Belmont, Suite 509/510, Chicago, Illinois 60657 Phone: (312)753-9465 Fax:(773)422-0940 info@taylorpsychchicago.com

AUTHORIZATION FOR RELEASE OF INFORMATION

HIPAA COMPLIANT PURSUANT TO 45 C.F.R. 164.508

Patient's Name: _____
Date of Birth: _____
Patient of Provider: _____

I hereby authorize Taylor Psychological Services, P.C. to use, release or disclose, the information set forth below, which may include mental health information, for the purposes described below.

I authorize the disclosure of the information set forth below to:

Name: _____ **Relationship to Patient:** _____
Address: _____
Phone: _____ **Fax:** _____

I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses, and Protected Health Information.

I authorize for the following Protected Health Information to be released/obtained:

___Psychological Evaluations ___Psychological Testing and/or Reports ___Academic or Educational Records
___Treatment Summary ___Admission and Discharge Records ___Medical Record
___Psychotherapy Notes ___Billing Records ___Other: _____

I authorize for the Protected Information to be used, disclosed, and/or received in connection with the following purpose:

___Continuity and coordination of care ___Provide Information for insurance purposes
___Facilitate evaluation or treatment ___Provide information for a legal matter
___Provide information for billing purposes ___Other: _____

Once the organization or person authorized to receive this information has received it, the information may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. However, information regarding HIV/AIDS, genetic testing, mental health, substance abuse and alcoholism may not be disclosed by the organization or person authorized herein to receive said information without my express written consent, except as otherwise permitted by applicable law. If I am requesting disclosure of psychological test material, I understand that all records related to any psychological testing shall only be disclosed to a psychologist designated by me.

Effective date for this Authorization: _____
The terms of this Authorization form will end one (1) year from the effective date with no further action on my part.

I understand that I have the right to:

1. Revoke this Authorization at any time by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this Authorization. However, actions already taken as specifically allowed by this form cannot be canceled by ending your authorization.
2. Inspect a copy of Protected Health Information being used or disclosed under federal law.
3. Refuse to sign this Authorization
4. Receive a copy of this Authorization
5. Restrict what is disclosed with this Authorization
6. I am not required to sign this Authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.

I acknowledge that I have read and fully understand this authorization as it applies to me. I have had an opportunity to ask questions about the uses and/or disclosures of my Protected Health Information described above and all of my questions have been answered to my satisfaction. I understand that by my signature below, I authorize the execution of the terms of this document.

_____	_____	_____
Date	Patient Signature *Minors 12 years and older must sign	Printed Name
_____	_____	_____
Date	Parent/Guardian/Representative Signature	Printed Name
_____	_____	_____
Date	Witness Signature	Printed Name