

**Chapel Hill Pediatric Psychology, P.A.**  
**205 Sage Road, Suite 201, Chapel Hill, NC 27514**  
**Telephone: (919) 942-4166      Fax: (919) 942-8693**

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION (PHI)**

I, \_\_\_\_\_, authorize Chapel Hill Pediatric Psychology,  
*Print name of patient/client*

P.A., and /or the administrative and clinical staff to  release and/or  obtain the following PHI

- Diagnosis/Assessment       Summary of assessment/treatment  
 Testing report       Clinical record notes       Information needed to file insurance  
 Other \_\_\_\_\_

This information should only be released to and/or obtained from: PLEASE CIRCLE

BCBS       CIGNA       United HealthCare

TRICARE       MEDCOST

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I am requesting this release of information for the following reason(s):

- At my request       Coordination of care       Treatment planning  
 Filing of insurance claims       Transfer of care       Legal consultation  
 Other: \_\_\_\_\_

This authorization shall remain in effect  
until termination of insurance and/or until

\_\_\_\_\_  
*Fill in an event that relates to the individual or the purpose of the use or disclosure*

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Chapel Hill Pediatric Psychology, PA. However, I understand that any revocation will not be effective to the extent that Chapel Hill Pediatric Psychology, PA, 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 Chapel Hill Pediatric Psychology, PA, generally may not condition psychological or psychiatric services upon my signing an authorization unless the 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 my information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
*Signature of parent, guardian, or authorized representative (indicate relationship)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of patient/client*

\_\_\_\_\_  
*Witness*

**PATIENT RESPONSIBILITY FOR INSURANCE NON-PAYMENT**

I understand that I am responsible for payment in full if my insurance company denies payment for any reason.

**X**

\_\_\_\_\_  
*Signature of parent, guardian, or authorized representative*

**X**

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of patient/client*

**X**

\_\_\_\_\_  
*Witness*