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 [X] Information needed to file insurance
[ ] Other _____

This information should only be released to and/or obtained from: (please circle)

BCBS State Health Plan UHC

TriCare Medcost

Phone:_____ Fax: _____

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

[ ] At my request [ ] Coordination of care [ ] Treatment planning
[X] Filing of insurance claims [ ] Transfer of care [ ] Legal consultation
[ ] Other:_____

This authorization shall remain in effect until Termination of insurance and/or treatment or until such time as
Fill in expiration date

_____
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.

X _____ X _____
Signature of parent, guardian, or authorized representative (indicate relationship) *Date*

_____ X _____
Signature of patient/client *Witness*

OVER

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 _____ X _____

Signature of parent, guardian, or authorized representative *Date*

_____ X _____

Signature of patient/client *Witness*