COMPLETE CHILDREN'S HEALTH, P.C.

Authorization to Disclose and Obtain
Protected Health Information (Psychology)

By signing this Authorization, I authorize and permit the use and disclosure of my protected health information for the purposes and manner described in this form.

Patient Name: ____ **Date of Birth:** ___/___/___
Last First MI

I authorize ___________________________, Complete Children's Health, phone: (402) 465-5600, fax: (402) 327-6060
(Name of Psychologist)

to DISCLOSE to and OBTAIN information from:

Name of Clinic/Organization/Provider: ____

Address: ____________________________________ **Phone:** _________________ **FAX:**______________________

Reason for Release: ☐ Transfer Records to New Provider; ☐ Coordination of care/ treatment planning;

☐ Legal Purposes; ☐ Other : ____

Disclose and Obtain the following Information: ☐ Entire Medical Record; ☐ Evaluation/consultation Reports

☐ Psychological / Social Information including observations and rating forms; ☐School Records; ☐ Verbal Report;

☐ Other ____

I understand that the information to be released may include information regarding psychological or psychiatric conditions, Drug and Alcohol usage, and AIDS/HIV/sexually transmitted disease. I understand that once this information is disclosed, it may be subject to re-disclosure by recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. By signing below, I acknowledge receipt of a signed copy of this authorization.

Expiration or revocation of authorization: This authorization shall expire one year from the date of this authorization. I understand I can revoke this authorization at any time by notifying CCH in writing.

Reimbursement: Complete Children's Health, P.C. reserves the right to recover costs involved in producing the requested Health Information. You or the Party to receive disclosure, named above, may be charged $20.00 plus 50 cents per page for handling and copying this information.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Age: If the patient is 19 years of age or older, the patient must sign and date the form.

____ ______________________ ____________________
Printed Name (Parent/Guardian if under 19 years old) Date Phone number if questions

____ ____________________________________
Signature Relationship to patient

For office use only: