Consultation and Treatment in Health Psychology/Behavioral Medicine

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Office/Patient Referrals/Cell

Authorization to Release Information

I, _____, hereinafter "Patient/Client", whose Date of Birth is _____, hereby authorize Helen L. Coons, PhD, hereinafter "Provider" to disclose (verbally and/or in writing) psychosocial consultations, behavioral health or mental health information and records obtained in the course of psychosocial consultations, health psychology and/or mental health evaluations and treatment of Patient/Client, including but not limited to, psychologist's recommendations for and diagnosis (if relevant) of Patient to:

_____ Office Phone: _____
_____ Office Fax: _____
_____ Office Email: _____
_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless the Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Dr. Coons to be effective.

Description of information to be disclosed. Patient/Client - initial each item to be disclosed and limited to:

_____ Psychosocial consultation
_____ Medical information
_____ Psychological or Health Psychology assessment/evaluation
_____ Diagnosis related to physical and/or mental health conditions
_____ Current treatment update
_____ Treatment plan
_____ Treatment summary
_____ Progress in treatment
_____ Continuing care plan
_____ Presence/participation in treatment
_____ Discharge/transfer summary

This disclosure of information and records authorized by Patient/Client is required for the following purpose(s):

_____ Treatment planning and coordination
_____ Documentation of participation in treatment

_____ Documentation of progress in treatment
_____ Continuing care planning
_____ Discharge/Transfer Summary
_____ Letters to support Patient/Client (e.g., accommodations, support animals, etc.)
_____ Educational planning, application, or related use
_____ Career planning, application, or related use
_____ Legal matters
_____ Other_____

Dr. Coons will not condition any consultation, evaluation or treatment upon Patient/Client signing this authorization and Patient/Client has the right to refuse to sign the form.

Patient/Client understands that any information used or disclosed pursuant to this specific authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule, although applicable laws may protect such information.

This authorization shall remain valid until: _____

_____ _____
Patient's Name (print) Date

_____ _____
Patient's Name (signature) Date