Johns Creek Psychology

Lorna L. Benbenisty, Ph.D. • Audrey Bloom, Ph.D. • Sonja Contin, Psy.D.

Saori Maruyama, Ph.D. • Diane Sperry, Ph.D.

10475 Medlock Bridge Road, Building 300, Suite 315, Duluth, GA 30097 • 678-935-9567 (phone) • 678-935-9568 (fax)

Authorization to Release Information

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I hereby authorize my psychologist _____

☐ To release ☐ To obtain ☐ To communicate (exchange)

information concerning _____(name of client) to:

Name of Person or Organization: _____

Address (if applicable): _____

Phone: _____ Fax: _____

The following information or documents are to be released:

☐ Notification of Initial Contact
☐ Information Pertaining to Treatment
☐ Psychological/Neuropsychological Report
☐ Periodic Progress and Evaluation Reports
☐ Attendance Reports
☐ Other _____

The information is needed for the purpose of:

☐ Treatment Planning
☐ Coordination of Treatment
☐ Psychological Assessment
☐ Consultation Purposes
☐ Utilization Review
☐ Consideration of Payment

I acknowledge that this consent will remain in effect for one hundred and eighty (180) days or until _____ (date).

I hereby release my psychologist from any and all liabilities, responsibilities, damages, and claims which might arise from the release of the information authorized above. I understand that the records released may contain alcohol and drug treatment information, medical information, AIDS/HIV information, or psychiatric and psychological information.

I know I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my revocation will not be effective to the extent that the psychologist 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 information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ (initial) I authorize this information to be faxed to the party indicated above, and understand the limits of confidentiality so doing creates.

Patient's Signature: _____ Date: _____

Patient's Representative: _____ Date: _____

Witness: _____ Date: _____

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information has been disclosed to you from records whose confidentiality is protected by federal law (42 CFR Part 2/37 CFR 1401) and in compliance with Section 408 of Public Law 92-255 (21 USC 1175). You are prohibited from making any further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.