Carolina Psychological Associates
5509-B West Friendly Avenue
Suite 106
Greensboro, NC 27410-4249

AUTHORIZATION FOR TWO-WAY RELEASE OF PROTECTED INFORMATION

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

RE: _____DOB:_____SS#: _____
(optional)

I authorize _____and Carolina Psychological Associates to release
(Therapist's Name)

_____ to _____
(Specific Information to be Released) (Name)

and for _____ to release_____
(Name) (Information Requested)

to _____ and Carolina Psychological Associates. I am requesting
(Therapist's Name)

that my therapist release this information for the following reasons: _____

_____.
This authorization shall remain in effect for one year unless otherwise specified.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 my psychologist/psychotherapist generally may not condition psychological services upon my signing any authorization unless the psychological 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 your information and no longer protected by the HIPAA Privacy Rule.

_____ or _____
(Client Signature) (Parent or Guardian Signature)

_____ _____
(Witness) (Date)

First Sent: _____ _____ Follow-Up: _____ _____
(Date) (Initials) (Date) (Initials)