Springfield Psychological
1489 Baltimore Pike, Suite 250
Springfield, PA. 19064
(610) 544-2110

Exton
Havertown
King of Prussia
Philadelphia
North Wales
Sinking Spring
Springfield
Trevose
West Chester

AUTHORIZATION FOR OBTAINING OR RELEASING CONFIDENTIAL MEDICAL INFORMATION

I, ______________________________ ***of*** ____
(Patient Name) **(Number & Street)**

____
(City, State) ***(Zip Code)***

Date of Birth*:* ____________________ ***Social Security Number:*** ___________*xxx-xx-*_____________________

Hereby Authorize *Springfield Psychological* to:

◯ **Release Medical Information TO:** ◯ **Obtain Medical Information FROM:**

Organization and/or Person and/or Self:______________________________ Relationship to Patient: ______________

Address: ____

Telephone Number: __________________________ Fax/Email Address**: ________________________________

The following information (Please check all that apply):

( ) Progress Notes ( ) Psychiatry Notes ( ) Assessment/Testing Notes
( ) Other: ____
( ) Verbal Exchange: ____

This release of information is valid for <u>the current episode of care</u>, unless otherwise specified below:
____

The purpose of this disclosure is for (Please select one):
( ) Transfer of Care to another Healthcare Provider ( ) Personal Copy ( ) Coordination of Care
( ) Other (specify): ____

Authorization: I am aware that I can refuse to sign this authorization. I am further aware that this information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule. I understand that I have the right to revoke this authorization in writing, at any time, by sending such written notification to the office address above. I am aware that my revocation will not be effective to the extent that this office 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 legal right to contest a claim. I understand that Springfield Psychological generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating protected health information for disclosure to a third party. **We <u>DO NOT</u> release any confidential medical information which will not be used for treatment.**

**I authorize communication of this information via mail, courier, telephone conversation, electronic mail, or facsimile transmittal. I understand that by providing an address for electronic mail as listed above I agree to the electronic exchange of information over the internet and understand the risks associated with this mode of communication.

______________________________	______________		___________
Patient Signature	Date of Birth		Date
Parent/Legal Guardian Name (Print)	Parent/Legal Guardian Signature	Relationship to Patient	Date
Parent/Legal Guardian Name (Print)	Parent/Legal Guardian Signature	Relationship to Patient	Date