Psychological Services & Human Development Center, Inc.

220 Commerce Drive-Suite #401
Fort Washington, PA 19034
(215) 540-5860
Fax: (215) 540-5864

630 Fairview Rd-Suite 209
Swarthmore, PA 19081
(610) 544-3660
(610) 544-3662

Authorization to Release Information About You

ACCT:____________

Client Name_________________________ Birth date ________________ SS#__________________

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

By initialing on the line below, I authorize and give my consent for my therapist and/or the administrative and clinical staff of PSHDC, Inc. to release my psychotherapy notes.

____

Initials

This information should only be released to (name and address of person to whom the information is to be released):____

____

I am requesting my therapist to release this information for the following reasons ("at the request of the individual" is all that is required if you do not desire to state a specific purpose):______________________

____

This authorization shall remain in effect until one year from today.

I have the right to revoke this authorization, in writing, at any time by sending such written notification to PSHDC, Inc. However, my revocation will not be effective to the extent that PSHDC, Inc. has taken action in reliance on the authorization or if this authorization was released as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment with PSHDC, Inc. is not contingent upon my agreement to sign this authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

I have been informed that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) by written or oral communication to PSHDC, Inc. I understand that this authorization is voluntary. I have also been informed of my right, subject to Section 7100.11.3 of the regulations promulgated under the Mental Health Procedures Act of 1976, to inspect the information to be released. Furthermore, I consent to the disclosure of information, if any, relation to my drug or alcohol abuse or dependency provided that disclosure is limited, pursuant to Section 8 © of the Pennsylvania Drug and Alcohol Abuse Control Act of 1972, to: 1) medical personnel for the purpose of diagnosis and treatment; and 2) government or other officials exclusively for the purpose of releasing benefits due me as a result of my drug or alcohol abuse or dependency. I certify that this form has been fully explained to me and that I understand it. I know I may have a copy of this authorization.

_______________________________	________________	____________
Signature of patient	Date	Rec