RACHEL LACY, PSY.D., P.C.
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AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

I authorize the following person(s) or organization to receive or release information to or from Rachel Lacy, Psy.D., P.C.:

Name of Physician: _____
Address: _____
_____

The following individually identifiable health information may be used and/or disclosed: Check all that apply:

__ Discharge summary
__ Face sheets w/ final diagnosis, complications and procedures
__ History and Physical Records
___ Outpatient Clinic Notes
__ Inpatient Records
___ ER records
___Consultation Reports
__ Outpatient Records
__ Therapy Progress notes
__ Psychological Reports (INITIAL:___)
__ Neuropsychological Reports (INITIAL:__)
__ Letters
__ Raw Data (INITIAL:___)

Dates of treatment to be released: _____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions (as initialed above).

Reason or purpose for the use and disclosure of information:
_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we 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.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT RELEASE OF YOUR RECORDS MAY NOT ASSIST YOU IN OBTAINING DISABILITY OR SUCCEEDING IN A LEGAL CASE.

_____ _____
Signature of Patient (or guardian / personal representative) Date