WOODVIEW
Psychology Group

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize and request Dr. _____ of Woodview Psychology Group (WPG) to release and/or obtain the information described below pertaining to the treatment of _____whose date of birth is _____ to/from:

Person/Organization: _____

Address: _____

Telephone: _____ Fax: _____

I authorize WPG to ☐ ***exchange with*** ☐ ***release to*** ☐ ***obtain from*** the party listed above the following type of information:

- ☐ Full Record
- ☐ Psychological Evaluation/Report
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ Other: _____
- ☐ Appointment Records
- ☐ School Records
- ☐ Billing/Financial Records
- ☐ Drug/Alcohol Records

The designated information ☐ ***may*** ☐ ***may not*** be transmitted by fax, electronic mail or other electronic file transfer mechanisms. WPG and the above designated person ☐ ***may*** ☐ ***may not*** discuss by telephone the content of the information released.

The purpose of disclosure:

- ☐ Coordination of Care/Treatment Planning
- ☐ Academic Planning
- ☐ Other: _____
- ☐ Transfer Care
- ☐ Legal Proceedings

I understand that if the authorized recipient of this information is *not* a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that this authorization is voluntary. WPG will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

This authorization will expire one year from the date I signed the authorization. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: Woodview Psychology Group, 70 E. 91st Street, Suite 210, Indianapolis IN 46240. I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization.

_____ _____

Signature of Client or Personal Representative Date