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AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION (PHI)

This form when completed and signed authorizes the release of your protected health information

I authorize Constance A. Kehrer, Ph.D. to

() release () obtain **information from the records of:**

Client Name: _____ Date of Birth: _____

INFORMATION TO BE EXCHANGED WITH:

Individual or Organization: _____

Address: _____

Telephone: _____ Fax: _____

INFORMATION TO BE EXCHANGED:

_____ All Protected Health Information (PHI), including history, diagnoses, treatment goals, therapy notes, medications, drug and/or alcohol use, assessment (testing) reports, labs

_____ Protected Health Information (PHI) with the following limitations (e.g., specific treatments or dates). Please provide a specific and detailed description of the information that you want disclosed. **Reminder:** Information that is not covered by HIPAA rules or psychological services provided to create health information for a third party is not protected; for example, evaluations and/or therapy contracted with the court, department of corrections, social security administration, & public school system.

I also agree to the release of health care information regarding diagnosis and/or treatment for
HIV (AIDS virus) _____ Sexually transmitted disease(s) _____

FOR THE PURPOSES OF:

_____ Participation in psychological evaluation and/or treatment services
_____ Coordination of care between providers
_____ Transfer of care to a new provider
_____ Other (please specify): _____

This authorization expires in 90 days or Until the following occurs _____
(Not to exceed 90 days)

I understand that I have the right to revoke this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1. Write, sign and date a letter canceling your authorization
2. Sign, date and write **CANCEL** on this original form
3. Sign and date a revocation form.

Once this information is released, it is beyond our control. The recipient might re-disclose it, as HIPAA privacy laws may no longer protect it. I understand that my therapist may not condition psychological services upon my signing an authorization.

Client Signature _____ Date _____

Please also PRINT the name of person giving consent