

INTEGRATIVE HEALTH PSYCHOLOGY, P.A.

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Authorization to Release Protected Health Care Information

Client's Name: _____ Date of Birth: _____

Under Florida law, communications between a client and his or her psychologist/mental health provider are privileged and confidential. This form when completed and signed by you authorizes me and/or Integrative Health Psychology, P.A. to release and obtain your clinical record to/from the person or agency you designate below.

I hereby authorize **Louis F. Damis, Ph.D., ABPP/Integrative Health Psychology, P.A.** to release and obtain the record of my care to/from the party named below (unless limitations are noted here _____):

(Name of Agency, Facility, Practitioner, or Individual)

(Street Address)

(City, State, & Zip Code)

(Telephone Number)

All information is to be released by either party or only the following:

- Intake Summary Discharge/Tx Summary Psychological Evaluation
 Psychological Tests Other: _____

The purpose for the release of this information shall be for assessment, treatment planning, and treatment coordination and/or the reasons checked below:

- Insurance reimbursement Legal proceedings At the request of the individual
 Research Other: _____

This authorization and request to release or obtain information is made voluntarily on my part. I understand that my psychologist or counselor generally may not condition psychological or counseling services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Integrative Health Psychology, P.A. at the address printed on this letterhead. However, my revocation will not be effective to the extent that my provider or Integrative Health Psychology, P.A. have taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.

This authorization will remain in effect for six months following last date of service or _____ (date or event).

Signed: _____ Date: _____
(Client or authorized representative)

If this authorization is signed by a personal representative, a description of such representative's authority to act for the client must be provided: _____.