Permission for Release / Exchange Confidential Information

Please complete the following consent to authorize your clinician to communicate about your care with another person / entity outside of Primary Care Psychology Associates.

_____

Name of person / entity authorized to exchange information with Primary Care Psychology Associates on behalf of patient

_____

Street address, City, State, Zip Phone Fax

Re: _____ _____

Patient name Date of birth

I, _____(**name of patient/guardian**), hereby authorize Primary Care Psychology Associates (PCPA) and _____(**entity authorized to exchange records with PCPA**) to exchange information and for notes to be documented in patient medical record when applicable.

The type of information to be disclosed:

☐All relevant information ☐Medical Records only ☐Psychotherapy Notes only
☐Psychological/Medical Test Results ☐Mental Health Record Summary ☐Other:_____

The purpose of such disclosure: _____
Dates of records requested: _____
Exceptions:_____

I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place. I understand that federal regulations prohibit the recipient of my confidential clinical information from making any further disclosures of this information. I hereby release all parties stated within this form 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 my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization with certain exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations. I also understand that a fee may be associated with the release of my records, and that my records may not be released until I, or the responsible party, pay the fee. Furthermore, I recognize that my records may not be released if I have an outstanding balance with Primary Care Psychology Associates and until the balance is paid. This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Patient/Guardian Signature:_____ Date:_____

Second Guardian Signature:_____ Date:_____

(If patient is a minor, guardians are legally separated AND sharing custody of patient)

Witness Signature:__*Boris K. Todorov, Ph.D.*_____ Date:_____
Director of Clinical Services