CONSENT TO OBTAIN/RELEASE CONFIDENTIAL PROTECTED HEALTH INFORMATION

TO:_____ RE: _____(Pt's Name)

_____ _____ Pt's SSN)

_____ _____(Pt's DOB)

_____ _____(Pt's ID#)

I hereby request and authorize you to release to or exchange with ***Alysia Kirk, LCSW*** _____ ***39 White Avenue, Crafton, PA 15205*** _____ any and all protected health information (relative to the types of information checked below) on myself who was your patient during the following period of time _____. Please forward the indicated type of records ONLY to the person(s) named above:

___ Discharge/Termination Summary
___ Psychotherapy History
___ Medical History
___ Course of Treatment
___ Medication History
___ Neurological Report
___Progress/Nursing Notes
___ Reason for Referral
___ Developmental, Social or Placement History
___ Psychiatric Evaluation
___ Psychological/Achievement Test Results
___ Recommendations for Treatment
___ Attendance Record

Other (Specify)_____

I am requesting that Alysia Kirk, LCSW release this information for the following reason(s): ("at the request of the individual" is all that is required if the patient does not desire to state a more specific purpose.)

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Alysia Kirk, LCSW's office address at 39 White Avenue, Crafton, PA 15205. Such revocation, however, will not be effective to the extent that Alysia Kirk, LCSW has already 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. I further understand that Alysia Kirk, LCSW generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may no longer be protected by the HIPAA Privacy Rule. I further understand that this information is usually needed to assist in evaluation and treatment planning and that it cannot be released again without my written notice. This authorization shall remain in effect until (fill in expiration date): _____. If no expiration date is cited, then this authorization lapses 180 days from signature date.

I also authorize that a facsimile of this release is as valid as the original.

_____ _____ _____ _____

Patient's Signature Date Witness' Signature Date

_____ _____ _____

Patient's Name Printed Guardian/Legal Representative's Signature Date