RELEASE OF INFORMATION AND AUTHORIZATION FORM

Pediatric Psychological Associates, PLLC
9700 Park Plaza Avenue, Suite 106, Louisville KY 40241 - phone (502) 429-5431 fax (502) 429-5439

Patient Name _____ **Date of Birth** _____

Address _____
Street City State Zip
Phone Number _____

_____ I DO NOT WISH TO HAVE ANY INFORMATION DISCLOSED TO MY PEDIATRICIAN
I, the undersigned hereby authorizes the sharing of the following Protected Health Information regarding the individual (patient) named above to the person or organization listed below.

The information will be disclosed _____ to and/or _____ from the below individual or organization:

_____
Individual's Name, Title & Organization

_____
Address **City** **State** **Zip**

_____
Telephone number, Fax number, and/or email address

I understand that the following items from my Protected Health Information will be shared:

☐ Case Progress Notes ☐ Psychological Testing ☐ Psychosocial History ☐ Treatment Plan & Summary

☐ Medical History ☐ Admissions & Discharge Summaries ☐ Recommendations ☐ Ongoing Progress

Other:_____

Information may be:

☐ Mailed ☐ Reviewed Only ☐ Discussed by phone ☐ Discussed in person ☐ Picked up by: _____

☐ Faxed* ☐ Emailed* * I understand the limits of confidentiality which emailing or faxing may create.*

1. **I understand the purpose for sharing this information is for:**

   ☐ Treatment Collaboration ☐ Evaluation ☐ Insurance Claim ☐ Academic Placement

   ☐ Case Consultation ☐ Other: _____

2. **I understand that I may refuse to sign this authorization and that Pediatric Psychological Associates will not allow my refusal to interfere with the receipt or payment of behavioral health services.**

3. **I understand that this authorization is subject to revocation at any time in writing to Pediatric Psychological Associates except to the extent that action has been taken based on my authorization; or obtained my authorization for the purpose of receiving reimbursement from a third party payer.**

4. **Unless previously revoked, this authorization shall expire 90 days from date of consent for one time release and one year for releases to persons providing on-going services to the patient such as school personnel, psychiatrists, pediatricians, etc.; or after the following event has occurred or condition has been met: _____.**

5. **I understand that pursuant to KRS 304.17A-555 – Patient's Right to Privacy Regarding Mental Health or Chemical Dependency—Authorized Disclosure. My Protected Health Information, used and/or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining specific written consent for redisclosure.**

_____
Signature Date ☐ Parent ☐ Legal Guardian ☐ Patient

_____
Witness Date