

**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 \_\_\_\_\_