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31799

MOSAIC
PSYCHOLOGICAL SERVICES, LLC

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Authorization Form Obtain/Release Information

Name of Patient (print)_____DOB:___/___/____

This form when completed and signed by you, authorizes me to obtain / release protected information from your clinical record to the person you designate.

I authorize Mosaic Psychological Services to **Obtain** / **Release** (type of information):

_____

This information should only be **Obtained from** / **Released to** (name of facility):

_____

I am requesting my psychologist/therapist to **Obtain** / **Release** this information for the following reasons:

Continuity of Care

_____

This authorization shall remain in effect until (date): One Year from date of Signature.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 understand that my psychologist/therapist generally may not condition clinical services upon my signing an authorization unless the clinical 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 the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient:_____Date:_____

Signature of Parent /Guardian:_____Date:_____

Witness:_____Date:_____