PSC
PSYCHOLOGICAL
SOLUTIONS CENTER

Authorization for Release of Information

Patient Information

Name: _____

Street: _____

City/Town: _____ State: _____ Zip Code: _____

Date of Birth: _____

Authorization to Release

I authorize Jeffrey A. Betman, Ph.D. to share and receive information about me that may include diagnosis, treatment notes and treatment progress. Sharing may be in writing or by phone.

Reason for Sharing

Please describe the reason(s) for sharing your information. If you do not want to list a reason, you may simply write “at my request” if you are initiating the request.

_____

_____

Who May Receive my Information

The person or organization to be shared with:

_____

_____

The Information to be Shared:

List out what information is to be shared. This could include treatment progress, treatment summary or treatment plans.

_____

_____

How Long This Authorization Lasts

This permission to share my information is good until (specify date) _____. If I do not list a date this permission will last for one year from the date it is signed.

I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to Jeffrey A. Betman, Ph.D.

I understand that I do not have to give permission to share my information if I choose not to.

I understand that if I choose not to give this permission or cancel this permission I will still be able to receive treatment as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

Other Important Points

I have a right to revoke this authorization at any time unless Dr. Betman has already taken action in reliance upon it.

The revocation will not apply to information that has already been released pursuant to this authorization.

The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Once the above information is released, Dr. Betman has no control over what happens to that information. Released information may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Michigan law may protect such information.

Authorizing the disclosure of the information identified above is voluntary.

I have a right to receive a copy of this authorization.

Sign and Date This Release

_____ _____

Your Signature Today's Date

_____

Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as a parent of a minor child, a guardian or health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____