HRA PSYCHOLOGICAL SERVICES

Release of Information

General consent to disclose protected personal information
for treatment, evaluation, and payment purposes.

Subject of disclosure (name): _____ DOB: _____

I authorize _____
(name of person or organization releasing information)

_____
(address / phone / fax / email)

to disclose protected information about me to:

_____
(name of person and organization receiving information)

_____
(address / phone / fax / email)

The disclosed information may include:

___ diagnosis, dates of service, billing information
___ test scores and evaluation results
___ medication records
___ medical lab test results
___ progress notes (problems, symptoms, status, plans, information observations, diagnosis, medications)
___ academic records
___ other _____

The purpose and need for the disclosure:

___ insurance authorization and billing
___ assessment, diagnosis, planning
___ treatment provider communication
___ attorney or court request, deposition or court testimony
___ at my request (if you elect to not state a purpose)
___ other: _____

Information may be transmitted electronically, by facsimile, mail, or by telephone unless I specifically request that one or more of these means be excluded.

This consent will remain in effect until (date)_____; OR until the events that are the cause of this consent are concluded. I have the right to revoke this consent verbally and/or in writing at any time.

_____ _____ _____
printed name signature date

The reverse side of this document contains important information regarding my rights.

I have the right to revoke this consent for disclosure of protected personal information at any time. I may be requested to put this request in writing. The revocation will not be effective to the extent that action has already been taken in reliance on the consent, or if this consent was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.

I understand that such information can not be disclosed about me without my written informed consent unless otherwise required by law. I understand that information disclosed pursuant to this consent may be subject to re-disclosure by the recipient of the information and no longer protected by privacy laws and Policies.

I understand that the **information in my clinical record may contain** name, address, phone number, social security number, insurance information, medication records, dates of service with start and stop times, the modalities and frequencies of treatments used, results of clinical tests, and summary information about diagnosis, functional status, the treatment plan, symptoms, prognosis, progress to date. The clinical record may contain psychiatric, substance abuse, and health information. HRA Psychological Services will make every effort to disclose only the **minimum amount of information necessary** to conduct the activity that is the subject of this consent.

I understand that “psychotherapy notes” are not subject to disclosure with this general consent form. Psychotherapy notes are given a special level of protection under Federal law (HIPAA), and their disclosure requires a separate Authorization form.

HRA Psychological Services (and each of its employees) makes every effort to secure and protect individually identifiable health information. This consent form was developed to be compliant with all relevant Federal and State of Michigan law regarding the handling of information obtained in the process of receiving psychological services.

HRA Psychological Services maintains policies for the management of protected health information, including a process for handling complaints or concerns regarding possible violations of privacy rights. Anyone at HRA Psychological Services can give me information about my privacy rights, upon request. Anyone at HRA Psychological Services can give me a paper copy of the Federal HIPAA Privacy Rule NOTICE, or I can ask to review HRA policies on privacy with my provider, the clinical director, or the HIPAA privacy officer.

This form is HIPAA compliant.