SERENITY NEUROPSYCHOLOGY, PLLC

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208-957-5450 (phone); 208-957-5292 (fax); www.idahoserenitycounseling.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Serenity Neuropsychology, PLLC to obtain and/or release my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form and that I will receive a copy of this form after I sign it, if I ask for it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.
I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name:____________________________________ **Date of birth:**_________________________

Persons/organizations from/to which Serenity Neuropsychology, PLLC is given permission to obtain___________ **and/or release**___________ **the information:** please **initial** the appropriate line(s)

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The specific information to be obtained and/or released is specified below:

☐ **Complete Medical Record**

Or specify one or more of the following:

☐ Neuropsychological Report	☐ Psychological Report	☐ Drug/Alcohol Related Notes*
☐ Clinical Therapy Notes	☐ Billing and Claim Records	☐ Physician Notes
☐ Laboratory	☐ (Other – specify) _______________________________________	

This information is to be used/disclosed for the following purposes(s) only: ________________________

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(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on ____ (state date or event).

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information.

☐ **Yes** ☐ **No** **Initials**___________

____ ______________________

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

Printed name of patient's representative (if applicable):_______________________________________

Relationship to the patient (if applicable):____

YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT

*Notice to recipient: *Federal regulation 42 CFR Part 2 prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.