Authorization for Release of Confidential Psychological Records and Protected Health Information

Client Name:

In order to protect your right to confidentiality, your written authorization is required if you request information to be shared with another person or agency.

I ___________________________________ authorize Dr. Eva Benmeleh (DrEvaTherapy) to:

☐ release information ☐ to obtain information ☐ exchange information

The following (name, address, phone, fax):

All information pertaining to treatment of myself, or my dependent-

The following information pertaining to myself, or my dependent-

☐ assessment ☐ testing/treatment summary ☐ recommendations
☐ treatment progress ☐ psychological records

for the purpose(s) of:

☐ evaluation/assessment ☐ other (specify)

This consent will automatically expire:

- One (1) year after the date of my signature below
- At the end of evaluation/treatment

You have the right to revoke this authorization in writing at any time by sending such written notification to our office. However, your revocation will not be effective to the extent that we 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.

By signing below, you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. You are indicating that you understand that Dr. Eva Benmeleh generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for 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, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

____

Signature Print Name Date

____

Witness Print Name Date

ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED: If you have received this information in error please contact my office as soon as possible to arrange for the return of the received material. This information may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed.