Psychological Counseling Services, Ltd.
Intensive Steps to Health and Wholeness
7530 East Angus • Scottsdale, Arizona 85251 • 480-947-5739 • pcs@pcsearle.com

Authorization Form

480-946-7795Fax

This form, when completed and signed by you, authorizes Psychological Counseling Services, Ltd. (PCS) to release and/or request protected health information from your clinical record to the person you designate.

Re: Client/Patient Name________________________________Date of Birth________________

Address____

City State Zip Code

Phone #____

Name of requesting PCS Therapist:____

I authorize Psychological Counseling Services, Ltd. to release- Please initial this section where appropriate:

_____ Psychotherapy Notes **_____ Telephone Contact/Consultation**

_____ Psychological Exam and/or Testing Results **_____Treatment Summary**

_____Thank You For Referral Letter/Call **_____ Medical Records**

_____ PHI Only **_____Other (Please be specific and detailed about your request below:)**

____

This information should only be released TO OR FROM: (ONE PERSON/ORGANIZATION PER FORM)

____
Name of person, party, or agency

____
Address **City** **State/ Zip Code**

____
Telephone Number **Fax Number** **Email Address**

This authorization shall remain in effect until ________________________ or one year from the date signed or until:
____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to PCS. However, your revocation will not be effective to the extent that PCS has 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 PCS and my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological 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.

X______________________________________ X______________________________________ X______________
Signature of Self, Parent, or Guardian **Printed Name** **Date signed**

____
Signature of Self, Parent, or Guardian **Printed Name** **Date signed**

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

07/14/04eh 11/16/04 eh 01/07/05 eh 07/11/05 eh 11/15/05eh