WEINSTEIN WELLNESS

Erica Weinstein, MEd., NCC, LCPC
Erica@weinsteinwellness.com | 410-960-3209

Patient Authorization for Disclosure of PHI (Personal Health Information)
RELEASE OF INFORMATION

Client Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Birthdate: _____

I, _____, authorize Erica Weinstein, LCPC to: _____send _____ receive the following _____to _____from:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES

___ Academic Testing Results
___ Behavior Programs
___ Progress Reports
___ Intelligence Testing Results
___ Medical Reports
___ Personality Profiles
___ Psychological Reports
___ Psychological Testing Results
___ Service Plans
___ Summary Reports
___ Vocational Testing Results
___ Entire Record, except Psychotherapy Notes
___ Other (Specify) _____

The above information will be used for the following purposes:

___ Planning Appropriate Treatment or Program
___ Continuing Appropriate Treatment or Program
___ Determining Eligibility for Benefits or Program
___ Case Review
___ Updating Files
___ Other (Specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 & 164) & Title 45 (Federal Rules of Confidentiality of Alcohol & Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if the recipient is not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, & after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, & who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your Relationship to Client:
_____ Self
_____ Parent/Legal Guardian
_____ Personal Representative
_____ Other – Describe_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client Signature: _____ Date: _____

Parent/Guardian/Personal Representative (if applicable) Signature:
_____ Date: _____

Witness (if client unable to sign) Signature:
_____ Date: _____