Wynns Family Psychology

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Authorization to Exchange Confidential Health Information

I, (Patient/Client Name) _____(DOB) _____, authorize Wynns Family Psychology (WFP) to ☐ Exchange ☐ Verbal ☐ Written (select all that apply) communication with:

Name(s)/Agency: _____
Address: _____
Phone: _____ Fax: _____ Email: _____

Regarding the following specific health information: (Please check appropriate/applicable information below)

☐	Psychiatric/Psychological Intake	☐	Educational History	☐	School Records
☐	Progress Notes	☐	Medical History	☐	Medical Tests/ Labs/ Studies
☐	Appointments/Scheduling	☐	Developmental/ Social History	☐	HIV Status
☐	Treatment Plan	☐	Financial Information/Payments	☐	Treatment Summary
☐	Psychiatric/medical/alcohol/drug abuse evaluation, treatment records, and/or discharge summary	☐	Psychological/ Educational/ Developmental Testing	☐	Other, please specify:

For the purpose(s) of: (please check appropriate/applicable information below):

☐	Coordination or Transfer of Care	☐	Collateral Interviewing	☐	Treatment Planning
☐	Forensic/Court-involved Services	☐	Evaluation/ Testing	☐	Other, please specify:

Terms of authorization: I understand by signing this authorization, I am voluntarily giving my consent to the disclosure of protected health information. I understand that I may refuse to sign this authorization to release information form. I understand that my services at WFP are not conditioned upon my signing this authorization unless the services are provided to me for the purpose of creating protected health information for disclosure to a third party. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and will no longer be protected by the HIPAA Privacy Rule. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may request a copy of this signed authorization. I understand that I may withdraw this consent in writing by emailing my provider at WFP directly or sending a letter to WFP. I understand that my withdrawal of consent will not apply to information that has already been released. This withdrawal of consent will only stop the listed parties from sharing information after they know my consent has been withdrawn.

Expiration/Revocation of authorization: I understand that unless I specify below, this signed authorization is good until one year from the date of my signature below, and that it encompasses consent to release information from before the signature date as well as additional information received after this consent is signed. In addition, I understand that information may be shared in writing, via email, in computerized form, and/or in meetings or by telephone. I do not wish to authorize the release of my record for one year. I wish my release to expire on _____.

Patient Signature: _____ Date _____

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

Signature of Parent/Guardian/Personal Representative: _____ Date _____

Relationship to Patient: _____