Clinical Psychology Associates of North Central Florida. P.A.

Mail all Forms to: **Clinical Psychology Associates of North Central Florida, P.A.**
2121 NW 40th Terrace Suite B
Gainesville, FL, 32605
(Phone) 352 - 336-2888

Fax copy to: (352) 371-1730
__(please check) facsimile or copies to be honored as originals.

CPANCF.COM

Patient Name:_____ SSN/ID_____ DOB_____

RELEASE OF CONFIDENTIAL INFORMATION FROM YOU OR YOUR FACILITY TO CPANCF, P.A.

AUTHORIZATION FOR OUTSIDE AGENCIES OR INDIVIDUALS TO RELEASE CONFIDENTIAL PROTECTED HEALTH INFORMATION, PSYCHOLOGICAL INFORMATION, EDUCATIONAL RECORDS AND/OR ALCOHOL AND DRUG TREATMENT RECORDS

TO RECEIVING AGENCIES/INDIVIDUALS:

PLEASE NOTE THAT SINCE EACH ITEM WILL BE INDIVIDUALLY SPECIFIED, THIS FORM DOES NOT CONSTITUTE A GENERAL RELEASE OF INFORMATION.

ALSO NOTE THAT PATIENT SIGNATURE ALLOWS TREATMENT OF COPIES OF THIS FORM TO BE TREATED AS AN ORIGINAL. THAT IS TO MEAN YOU ARE TO HONOR THIS FORM AS HAVING THE SAME LEGAL OBLIGATION AND FORCE AS THE ORIGINAL SIGNED COPY.

PATIENT AGREEMENT AND AUTHORIZATION TO RELEASE:

This form when completed and signed by you, authorizes outside agencies or individuals to release protected information from your clinical record to Clinical Psychology Associates of North Central Florida, P.A. by mail, facsimile, or personal communication. It authorizes any receiving individual or entity to honor copies of this signed form as having the same legal authority and force as the original.

You agree and understand that this form does not constitute a general release, and that by checking off or specifying information below you are agreeing to an informed release of specific sensitive and confidential information.

I authorize the following individuals, agencies or their representative to release to Clinical Psychology Associates of North Central Florida, P.A. (CPANCF) and/or its administrative and clinical staff the following individually checked items in their entirety:

____ Intake Summary
____ Discharge/Treatment Summary
____ Treatment Plan
____ History Forms
____ Mental or Psychiatric Examination
____ EMS Records

____ Psychological and Neuropsychological Testing
____ Raw Psychological Test Data
___ Current and Future Progress Notes
___ Participation, Progress and Attendance in Treatment
____ Social History and Nursing Notes

__ Hospital Admission and Discharge Summaries
__ Medical and Laboratory Results
__ Alcohol and Drug Screen Results
__ Letters or updates to CPANCF
__ Alcohol and/or Drug Abuse Evaluation & Treatment
__ Confidential Psychological and Mental Health Information for Treatment Care Coordination
__ Current and Past Progress Notes
__ Educational and Academic Records including results of standardized testing and school psychological records.
__ Emergency Room Records and Notes
__ Patient History forms

Other: _____
_____

____This authorization shall authorize for release of information from_____ to _____.
____ This authorization shall authorize for release of information from _____ until 120 days following the termination of therapy or closure of my case or file with Clinical Psychology Associates of North Central Florida,

RELEASE OF CONFIDENTIAL INFORMATION FROM YOU OR YOUR FACILITY TO CPANCF, PA.

I am requesting the following providers or agencies to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____
_____
_____

This release shall authorize the following individuals or agencies to release the above specified information:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we or the receiving agencies or individuals 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 Clinical Psychology Associates of North Cental Florida, P.A. 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 this information, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

Name _____ Date of Birth_____ SSN/ID:_____

Signature of Patient or Authorized Representative_____ Date _____

Witness_____ Date_____

_____

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.