DEDHAM CONSULTATION CENTER, LLC

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AUTHORIZATION FOR THE RELEASE OF INFORMATION

This form, when completed and signed by you, authorizes Dedham Consultation Center, LLC to provide OR collect protected information from your clinical record to/from the person(s) or organization(s) you designate.

Patient Name:_____Date of Birth:_____
Address:_____
City:_____ State:_____Zip:_____

I authorize Dedham Consultation Center, LLC
To: _____Obtain from or _____Release to

Facility/Individual Name:_____
Address:_____
City:_____ State:_____Zip:_____
Phone:_____ Fax:_____

Purpose of Request:
_____Transferring to Another Provider _____Outside Consult _____Personal Use
_____Other(please specify)_____

Information to be Released:
_____Psychotherapy Notes _____Psychopharmacology Medication Records
_____Laboratory Reports/Test Results _____Psychiatric/Psychological Test Results
_____Other(please specify)_____

I understand that:

- I may revoke this authorization at any time by sending written notification to my provider at Dedham Consultation Center, LLC. Revocation will not be effective to the extent that Dedham Consultation Center 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 may refuse to sign this authorization knowing that my psychiatrist generally may not condition psychiatric services upon my signing unless the psychological services are provided to me for the purpose of creating health information for a third party.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____

Signature of Patient (or Representative) 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.