Authorization To Release/Receive Medical Records

Patient's Legal Name:

I AUTHORIZE:
Wise Psychological Services, LLC
1200 East Woodhurst T300
Springfield, Missouri 65804

_____
Name

_____
Address

_____
City **State** **Zip**

_____
Date of Birth

_____ **To release and/or** _____ **To receive**

information/records which may include protected health information under HIPAA. I request release of the following:

____ Billing/Scheduling ____ Protected Health Information ____ Verbal

I am requesting my provider to release this information for the following reasons:

____ At the request of the individual (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.)

____ To another health care provider for the purpose of obtaining health care.

____ Other, please specify: _____

The information should be released and/or received by:

_____
Name of person/physician/agency/institution

_____
Address

_____
City State Zip

_____
Phone Fax

This release waiver remains in effect until canceled by written notification to Wise Psychological Services, signed by the client or the client's legal representative. However, your revocation will not be effective to the extent that the person/agency 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 my provider generally may not condition health services upon my signing an authorization unless the 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. For the purpose hereof "Records" and/or "Information" shall include all confidential HIV related information (as defined in A.R.S. Section 36-661), confidential communicable disease related information (as defined in A.R.S. Section 36-661), and confidential alcohol or drug abuse-related information (as defined in 42 CFR Section 2.1 ET SQ).

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian or Personal Representative, please indicate which Date