



Woodview Psychology Group, LLC

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Authorization for Disclosure of PHI

I, the undersigned, hereby authorize Woodview Psychology Group, LLC to use or disclose protected health information in the manner described in this authorization for the following patient:

Patient name: _____ **Patient DOB:** _____

I understand that my signature on this form is voluntary and that not signing will not affect the ability to receive treatment at this practice. I understand that this release will expire in 180 days, unless revoked by me which I have the right to do at any time. I understand that any revocation will not apply to any PHI that has already been released in reliance to this authorization and to PHI created expressly for disclosure to the person/entity listed below. I understand that the PHI disclosed may be subject to re-disclosure by the person/entity receiving it and no longer protected by federal privacy regulations except in the case of drug/alcohol treatment which must be clearly stamped "Do not re-disclose" and protected accordingly under 42 CFR part 2. I understand that any questions I have about the use or disclosure of this PHI can be directed to Woodview Psychology Group at any time.

I give permission for Woodview Psychology Group to:

- Release PHI Obtain PHI Exchange PHI

PHI to be disclosed includes the following:

- Evaluation reports Progress notes Treatment Status
 Treatment summary Entire patient chart Other (Specify):

The purpose of the disclosure is to:

- Coordinate services Other (specify):

I authorize disclosure to the following person(s)/entity(ies):

Name _____ **Phone** _____
Address _____ **FAX** _____

Name _____ **Phone** _____
Address _____ **FAX** _____

Name _____ **Phone** _____
Address _____ **FAX** _____

Patient/legal guardian signature

Relationship to patient

Patient/legal guardian printed name

_____ (Witness)

Date: _____