# Pittsboro Pediatric Psychology & ADHD Clinic

## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, ____________________________________________________________,DOB:______________________

*Print name of patient/client*

authorize Heather Brewis Scheffler, Ph.D., and/or Pittsboro Pediatric Psychology & ADHD Clinic, P.A., to

*Initial appropriate box(es):*
RELEASE THE FOLLOWING PHI

- **[ ] Entire Record**
- [ ] HIV/AIDS Status
- [ ] Alcohol/Substance Abuse Information
- [ ] Diagnosis/Assessment
- [ ] File Summary
- [ ] Testing Report
- [ ] Therapy Notes
- [ ] Recommendations
- [ ] Information, as needed
- [ ] Other: ______________________

*Initial appropriate box(es):*
OBTAIN THE FOLLOWING PHI:

- **[ ] Entire Record**
- [ ] HIV/AIDS Status
- [ ] Alcohol/Substance Abuse Information
- [ ] Diagnosis/Assessment
- [ ] File Summary
- [ ] Testing Report
- [ ] Therapy Notes
- [ ] Recommendations
- [ ] Information, as needed
- [ ] Other: ______________________

This information should only be released to and/or obtained from:

______________________________________________________________________________

______________________________________________________________________________

Phone: ______________________________ Fax: ______________________________

I am requesting this release of information for the following reason(s) *[Initial appropriate box(es)]:*

[ ] At my request [ ] Information sharing [ ] Coordination of care (medical, educational, etc.)
[ ] Legal consultation [ ] Transfer of care [ ] Other: ______________________

This authorization shall remain in effect until ______________________________ or until such time as

*Fill in expiration date*

______________________________________________________________________________.

*Fill in an event that relates to the individual or the purpose of the use or disclosure*

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Heather Brewis Scheffler, Ph.D. However, I understand that any revocation will not be effective to the extent that Heather Brewis Scheffler, Ph.D., or Pittsboro Pediatric Psychological & ADHD Clinic, PA, 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 Heather Brewis Scheffler, Ph.D., generally may not condition psychological or psychiatric 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 my information and no longer protected by the HIPAA Privacy Rule.

______________________________________________ ______________________
Signature of patient/client Date

______________________________________________ ______________________
Signature of parent, guardian, or authorized representative (indicate relationship) Witness