Basset
Psychological Services, LLC

7850 Camargo Road
Madeira, OH 45243

Phone: (513) 271-9700
Fax: (513) 271-0700

REQUEST/AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name: _____ **Date of Birth:** _____

I authorize and give this consent voluntarily that information concerning myself or my child be released as outlined below. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing this information. I also understand that the provision of services is not contingent on my decision concerning the release of this information.

Please release information to:	**Please obtain information from:**
Basset Psychological Services, LLC	Basset Psychological Services, LLC
From:_____	**To:**_____
Address:_____	**Address:**_____
Phone/Fax:_____	**Phone/Fax:**_____
Specify information type:	Specify information type:
☐Assessment and diagnosis ☐Treatment plan ☐Progress notes ☐Treatment summary ☐Discharge summary ☐Psychological evaluations/testing ☐Educational/academic records ☐Medical records ☐Drug/alcohol treatment information ☐Billing records ☐Other_____	☐Assessment and diagnosis ☐Treatment plan ☐Progress notes ☐Treatment summary ☐Discharge summary ☐Psychological evaluations/testing ☐Educational/academic records ☐Medical records ☐Drug/alcohol treatment information ☐Billing records ☐Other_____
Dates of records requested:_____	**Dates of records requested:**_____

Purpose of disclosure:

☐Treatment/continuity of care ☐Medical care
☐Academic/education ☐Other _____

Prohibition of Redisclosure: This information has been disclosed to you from records where confidentiality is protected by federal law. Federal regulation prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by federal regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand and agree that this authorization will expire on _____/_____/_____(date) OR expire at (event) _____. I understand that after that date or event, no more of this information can be used or released to Basset Psychological Services, LLC, unless I sign a new authorization form.

Print Name_____ **Relationship to Client**_____

Signature_____ **Date**_____

Witness Signature_____ **Print Name**_____

REVOCATION OF CONSENT: You may revoke authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose medical information about you for the reasons indicated above. You understand that we are unable to take back any disclosures that we made before we received your written notice revoking your authorization. I hereby revoke the above authorization for release of information. Upon revocation of authorization, further release of specified information shall cease immediately, except otherwise allowed by law.

Signature of Client or Parent/Guardian:_____ **Date:**_____

Witness Signature: _____ **Date:** _____