Cahaba Psychology Center
2 Riverchase Office Plaza, #115
Birmingham, Alabama 35244
(205) 403-0955 Fax (205) 403-0956

Protected Health Information Consent Form

Patient's name: _____ DOB:_____

My permission is granted to _____ to

___ Release protected health information to:
___ Exchange protected health information with:
___ Obtain protected health information from:

_____

The following information may be included in this release:

___Clinical Intake
___ Consultation
___ Diagnosis
___ Medication Rx
___ Psychological/Psychiatric Evaluation
___Psychological/Psychiatric Treatment Records
___Teacher's observations, progress notes testing; achievement scores
___Emergency Notification
___Treatment Plan/ Outpatient Treatment Request
___Dates of Service
___Other_____

The purpose of this disclosure is:

___To facilitate evaluation and treatment
___For legal purposes
___For other:_____
___For disability determination
___For insurance purposes

This authorization will be valid for a period of One (1) year unless it is revoked prior to that time.

I hereby release _____and_____ from any and all liabilities arising from but not limited to the laws of the state of Alabama and/or any other states related to the disclosure of confidential or privileged information.

- You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining as insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological 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 re-disclosure by the recipient of your information of your information and no longer protected by the HIPPA Privacy Rule.

_____ Date_____
Patient Signature (Parent or legal guardian if patient is a minor or incapable)

_____ Date_____
Signature of □Parent □Legal Guardian □Legal Representative

_____ Date_____
Witness