Beacon Psychology Services LLC
Release of Information

Authorization for Disclosure of PHI

Patient Name: _____ **DOB:** _____ **Date Signed:** _____

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 this practice at any time.

I give permission for Beacon Psychology Services to:

_____ Release PHI _____ Obtain PHI _X_ Exchange PHI

PHI to be disclosed includes the following:

_X_	Treatment Summary	_X_	Testing/Evaluation Reports	_____	Entire Patient Chart
_X_	Treatment Status	_X_	School Academic Records	_____	Other (specify):
_____		_____			

The purpose of the disclosure is to:

_X_ Coordinate services _____ Aid in treatment planning _____ Other(specify):

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

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

_____ _____

Patient/Legal Guardian SIGNATURE Relationship to patient

_____ _____

Patient/Legal Guardian PRINTED NAME Witness