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PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

Patient/client name: _____

Date of birth: _____ Social Security No.: _____

My signature on this form indicates that I give permission to Aubrey K. Ewing, Ph.D. & Associates, P.A. and provider(s), _____ to release my protected health information to the following health care provider or other entity:

_____

_____

_____

I grant permission for the following specific information to be released:

_____ Chart notes
_____ Treatment summary
_____ Diagnoses
_____ Testing/evaluation results and reports
_____ Medical history/physical/lab work
_____ Dates of service
_____ Billing information
_____ Confirmation of attendance
_____ Verification of progress
_____ Date of termination
_____ Other _____

The purpose for this release/exchange of information is:

_____ Coordination of treatment
_____ Referral for service
_____ Discharge planning
_____ Other _____

I hereby release Aubrey K. Ewing, Ph.D. & Associates, P.A. and all others named above from any and all legal liability that may arise from the release of the identified protected health information. I understand that any disclosure is bound by Tile 42 of the Code Federal Regulations (chemical abuse/addiction clients), Florida Statues 294.459 (9b) and/or 90.53, 490, and 491 (psychiatric/psychological information), and the Health Insurance Portability and Accountability Act (HIPAA), and that re-disclosure of this information without my additional written authorization is prohibited.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I certify that I have read the information above and that I understand and agree to its content.

_____ _____ _____
Patient/client Signature Witness Signature Date