

Aubrey K. Ewing, Ph.D. & Associates, P.A.

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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 Title 42 of the Code Federal Regulations (chemical abuse/addiction clients), Florida Statutes 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