PSYCHOLOGICAL CARE ASSOCIATES, p.c.
A multi-specialty behavioral health practice

Arlington, Woburn, Stoneham & Chelmsford

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www.psycare.info

Authorization to Release Protected Health Information

I, the undersigned, do hereby authorize Psychological Care Associates, p.c. (PCA) to release my, or my dependent's Protected Health Information, including opinions, verbally or in writing, to:

Name: _____

Street Address _____

City/State/Zip _____

Telephone #: _____

PCA Contact:_____Tel: 781.646.0500 x_____ Fax: 781.646.7130

The purpose of the disclosure of this information is: ☐ Coordination of Care ☐ Educational Planning ☐ Transfer ☐ Referral ☐ Billing Matter ☐ Other (specify):

Information to be released: ☐ Entire record ☐ Diagnostic Evaluation/Consultation Note ☐ Progress Notes ☐ Termination/Transfer Summary ☐ Evaluations, Assessments & Tests, ☐ Other:

Alcohol or Drug Treatment: I specifically authorize release of this information, if part of my record. Initial: ✓

HIV status or testing: I specifically authorize release of this information, if part of my record. Initial: ✓

I have been informed that I have the right not to authorize the release or disclosure of my records.

This authorization will remain in effect, unless revoked, until _____/_____/_____, or, if not specified, until the completion of my care at Psychological Care Associates, p.c.

I understand that I have the right to revoke this authorization at any time. Should I decide to revoke this authorization, I agree to provide the revocation in writing. The effective date of any revocation will be that date upon which my doctor or therapist receives the revocation. PCA and the clinician(s), providing services through PCA reserve the right to terminate treatment if, in the treating doctor's or therapist's opinion, revocation of the authorization is detrimental to the provision of competent care.

I hereby indemnify and hold harmless, absolve and release PCA, my or my dependent's treating clinician(s), PCA's employees, agents, officers, directors and contractors from any and all responsibility concerning the confidentiality of my medical and/or psychological records and photocopies released as authorized herein. Furthermore, I do hereby waive any and all claims for liability which I might otherwise have for direct or indirect harm or damages caused by the release of records.

I agree to pay any necessary charges, in advance, for producing copies of my records.

✓ _____ _____/_____/_____
Patient Name (Printed) Date of Birth

_____ _____/_____/_____
Patient *Signature* (Parent or Guardian if a minor or dependent) Today's Date

_____ _____
Patient's Parent or Guardian Name (Printed) Relationship to Patient

A copy of this authorization shall be considered as valid as the original.