EXETER PSYCHOLOGICAL ASSOCIATES, INC.

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AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: ______________________________ **DOB:** ___________

I authorize Exeter Psychological Associates, Inc. to exchange information with:

____

- I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.
- You may refuse to sign this authorization.
- You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.
- I understand that the information being exchanged may contain information regarding alcohol and substance abuse treatment. (Note: Federal regulations govern the confidentiality of alcohol and drugs, Section 2.31 of P.L. 93-282. 42 CFR Part 2)
- I do _____ do not _____ authorize release of my records via FACSIMILE machine and understand there is a risk of misdirected information via misdialed phone number and/or misdirected release with the receiving facility/company.

Signature of patient or Legal Guardian: ____________________________________

Printed name of patient or patient's representative ___________________________

Relationship to patient: ______________________________ Date: ___________

5/27/2014