## PSYCHOLOGICAL SOLUTIONS, LLC
## HIPAA Authorization for Release of Health Information

**I. Information about the Use or Disclosure**
I hereby authorize the use and disclosure of my individually identifiable health information as described below:

**Persons/organizations authorized to provide information to another include**:
_ Psychological Solutions, LLC, HILLTOP BUILDING, 5035 MAYFIELD ROAD, SUITE #201, LYNDHURST, OHIO 44124, 216-291-1010 and fax 216-291-1014.
_ Other, please list complete information: _____
_____
_____
_____

**Persons/organizations authorized to receive information from another:**
_ Psychological Solutions, LLC, HILLTOP BUILDING, 5035 MAYFIELD ROAD, SUITE #201, LYNDHURST, OHIO 44124, 216-291-1010 and fax 216-291-1014.
_ Other, please list complete information: _____
_____
_____
_____

**Specific description of information to be used or disclosed (including date(s)):**
_____
_____
_____

**Specific purpose of the disclosure:**
_ At the patient's request
_ Other (please explain) _____

**This authorization will expire on** _____/_____/_____ or
_____
**Event**

(Indicate a date or an event relating to you personally or to the purpose of the authorization).

**Please turn to the next page**

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**II. Important Information About Your Rights**

I have read and understand the following statements about my rights:

· I understand that this authorization is completely voluntary and that I may revoke this authorization at any time prior to its expiration date by notifying the disclosing entity in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.

· I may see and copy the information described in this form if I ask for it (except psychotherapy notes).

· I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment), but if the information is being sought by a third party, such as for a pre-employment evaluation, I may not obtain the evaluation if I refuse to sign this form allowing disclosure to the third party.

· The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity, and, thereafter, may no longer be protected by federal law privacy rules. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

· I am entitled to receive a copy of this authorization and a copy of Psychological Solutions, LLC, Notice of Privacy Practices Form.

**III. Psychotherapy Notes**

A signed Authorization Form is required by HIPAA for the disclosure of medical/clinical information and/or Psychotherapy Notes. Note: an authorization for the release of Psychotherapy Notes may not be combined with an authorization for the release of other medical/clinical information. Therefore, if a patient requests their entire file there must be a separate Authorization Form obtained to release the medical/clinical information and another, second, Authorization Form obtained to release the Psychotherapy Notes.

**IV.**

**Signature of Patient :_____**

**Print Patient's Name: _____**

**_____/_____/_____**
**Date**

**OR**

***Signature of the Patient's Personal Representative:**
**_____**

**Print Patient's Representative Name: _____**
**_____/_____/_____**
**Date**
***Relationship to Patient, including Authority for Status as Representative:**
**_____**