The Oak Inside
CENTER FOR PSYCHOLOGICAL ASSESSMENT & COUNSELING

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Authorization for Release of Protected Health Information (PHI)

With your signature, this form authorizes Jaqui R. Otto, Ph.D. or Lisa Lawson, M.A., LPC to release/obtain protected information regarding the minor child named below to/from the organization(s) or person(s) you designate.

Child/Client's Name _____

Client Date of Birth _____ Parent/Guardian (for minor clients) _____

I authorize Jaqui R. Otto, Ph.D. or Lisa Lawson, M.A., LPC to (check one or both):

_____RELEASE information checked below _____OBTAIN information checked below

____Complete Medical/Clinical record	_____Testing/Assessment
____IEP/Educational record	_____Diagnostic Impressions
____Verbal Exchange	_____Clinical/Treatment Notes
____ Classroom Observation	_____Behavioral Checklists

To/From:

Agency/Person:	
Address:	
Phone Number:	Fax Number:
Email:	

Purpose of disclosure:

_____Coordination of care	_____Continuity of care
_____Treatment/assessment planning	_____Other

- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my/my child's Protected Health Information have acted in reliance upon this authorization.
- I understand that I do not have to sign this authorization and that staff at the Oak Inside may not condition treatment, payment, enrollment, or eligibility for treatment/benefits on whether I sign this authorization.
- I understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed.
- I understand the information disclosed by my authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) 45 CFR, Parts 160-164.

I agree that a copy of this release or fax of this release shall be valid as this original release. I understand there are inherent risks in faxing Protected Health Information released to anyone other than another health care provider. I understand I will receive a copy of this form after I sign it.

My authorization will expire: [ ] One year from this date [ ] Other: _____

_____ _____
Signature of Adult Client or Parent/Guardian **Date**

_____
Printed Name of Adult Client or Parent/Guardian