

RELEASE OF INFORMATION FORM

Applied Psychological Services, Inc.

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1. I am completing this form to allow the use and sharing of protected health information about

Patient Name _____ Date of Birth _____

2. I authorize this person or organization _____ Telephone# _____

Address _____

3. To use or disclose the following information:

- Admission summary
- Aftercare plans
- Discharge Summary
- Psychotherapy notes
- Treatment plans
- Lab reports of urine or hair drug screens
- Outpatient treatment records for physical, psychological, psychiatric or emotional illness and/or drug and alcohol abuse.
- Other _____

4. Dates of care included: From _____ to _____

5. To this person or organization _____ Telephone # _____

Address _____

If this box is checked, this release of information authorizes the RECIPROCAL release by and to both parties.

6. The information will be used for:

- Treatment planning
- Continuity of care
- Educational purposes
- Legal purposes
- Other _____

7. I understand and agree that this Authorization will be valid and in effect until _____
I understand that after that date, no more of the information can be used or released to this person unless I sign a new Authorization.

8. I understand that I can revoke or cancel this authorization at any time by sending a letter to one of the following: **Caroline Leavitt, Ph.D., -- Ashley Loyd, Psy.D., -- or Mary Sue Singletary, LPC.** If I do this, it will prevent any releases after the date it is received, but cannot change the fact that some information may have been sent or shared before that date.

9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 5 above, nor will it affect my eligibility for benefits.

10. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

11. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signature of client or his/her personal representative

Printed name of client or representative

Relationship to client

Date