Stephen S. Meharg, Ph.D., ABN - Licensed Psychologist WA#1656

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Authorization to Release Protected Health Care Information

PATIENT

Patient Name: ____Date of Birth:____________________

MRN or SSN: [ ] unknown [ ] ________________________________

FROM/TO

I authorize the use and/or disclosure of the health information described below for the above-named patient by the following entities:

Information is to be released to or from:	**Information is to be disclosed to or from:** **Stephen S. Meharg, Ph.D.** **945 11th Avenue - Longview, WA 98632** **Fax: 360-636-7372**

PURPOSE

For the purpose(s) of:

[ ] Request of patient or representative [ ] Coordination of care [ ] Assist with evaluation, diagnosis, and treatment plan

[ ] Legal proceedings [ ] Independent or Forensic Psychological/Neuropsychological Examination [ ] Research

[ ] Other: ____

INFORMATION TO BE DISCLOSED

Description or nature of the disclosed information (initial all that apply)

		Specially Protected Information
_____ Admission Summaries	_____ Pathology Reports	
_____ Discharge Summaries	_____ Radiology/Imaging Reports	_____ Mental Health Eval/Treatment Records
_____ History/Physical Exams	_____ Lab Reports	_____ Psychological/Neuropsychological Test Scores
_____ Consultations	_____ EKG or EEG Reports	_____ Substance Abuse Records
_____ Operative Reports	_____ ED Records	_____ HIV/AIDS and STD Information
_____ Medical Progress Notes	_____ Medication Records	_____ Genetic Testing Information
_____ Nursing Notes	_____ Billing Statements	_____ Legal Records
_____ Clinician Office Notes	_____ Academic/IEP Records	_____ Other: ______________________________

_____ Any or all health records listed above (excluding Specially Protected Information unless otherwise initialed)

_____ Other Information: ____

NOTICES

1. I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization contains HIV/AIDS, STD, mental health, substance abuse diagnosis and treatment, or genetic testing, Federal law and regulations including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.
2. I can refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for health care benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purposes of providing that information to someone else.
3. I may revoke this authorization at any time by appropriate written notification provided to the above-named disclosing entity on its designated form. Any such revocation will not apply to any activity already undertaken based on this authorization.
4. I can receive a copy of this authorization, and I may inspect and request copies of information disclosed by this authorization.

DATES

Unless revoked, this authorization is valid for 90 days from the date of signature, or for the following time period:

Beginning Date: ________/_________/__________ Ending Date _________/__________/_________

Not to exceed one year

SIGN

Signature: I have read this authorization and understand it.

____ __________________________________ _____/_____/_____

Signature of Patient or Representative Relationship to Patient (if not self) Date