Adena Shoshan, Psy.D.
Licensed Clinical Psychologist

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CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Authorization for Disclosure of Protected Health Information

Patient Name:_____ **Date of Birth**: _____

I authorize Adena Shoshan, Psy.D., to disclose and/or receive the requested outpatient psychiatric evaluation and/or treatment information, including protected health information, as specified below.

Information may be ▢ **released to** ▢ **received from**

_____ _____
Name of Person/Provider/Organization/Facility or Program Contact Name

_____
Address

_____ _____
Phone Fax

Purpose of Request:
▢ Discharge Planning ▢ Healthcare/Treatment
▢ Insurance Coverage ▢ Disability Determination ▢ Legal
▢ Personal ▢ Other_____

Specific Information Authorized (select one or more as appropriate):
▢ Evaluations/Assessments ▢ Diagnostic Impression ▢ Progress Notes
▢ Treatment Plans ▢ Treatment Summary ▢ Progress in Treatment
▢ Discharge Summary ▢ Attendance Information ▢ Entire Copy of Outpatient Record
▢ Other_____

My Authorization Will Expire:
▢ When the requested information has been received
▢ 90 days from this date ▢ One year from this date ▢ Other_____
▢ When I am no longer receiving services from_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Adena Shoshan, Psy.D. at the above address. However, my revocation will not be effective to the extent that actions have been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date