ASBELL
HEALTH STRATEGIES

Authorization for Release of Information

Client Name_____ Date of Birth_____

This form, when completed and signed by you,

__☐__ authorizes Laura Asbell, PhD, to release protected information from your clinical record to the person you designate and/or

__☐__ authorizes the person you designate to release information to Laura Asbell, PhD.

Name/Organization:_____

Address: _____ City/State/Zip: _____

Telephone: _____ Fax:_____

This authorization for disclosure of protected information applies to the following types of information:

__☐__Clinical Information __☐__Clinical Record Other (Please specify) _____

I am requesting the release of this information for the following reasons, and subject to the following limitations:

__☐__Continuity of Care Other (Please specify)_____

Limitations_____

This authorization shall remain in effect until: (Fill in an expiration date or an event that relates to the purpose of the disclosure.) __☐__Termination of Services Other (Please specify) _____

If this authorization does not contain an expiration date or event, it expires 90 days from the date of my signature.

Revocation: I understand I have the right to revoke this authorization, in writing, at any time, by sending such written notice to Asbell Health Strategies. However, my revocation will not be effective to the extent that action has been taken in reliance on my authorization or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

Condition: I understand that Dr Asbell generally may not condition services upon my signing an authorization unless the services are provided for the purpose of creating health information for a third party.

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

I have read and understand the nature of this release.

Signature of Client _____ Date_____

Signature of Parent/Legal Guardian/DPOA_____ Date_____

Note: A photocopy or facsimile of the above signatures shall be considered in lieu of the original.

If there is a fee for this service, please obtain prior approval from Asbell Health Strategies.

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