WILSON psychological associates

Providing competent, caring
Christian mental health care…

Authorization to Use and Disclose Protected Health Information

Please use a pen to complete all sections of this form.

_____
Patient Name (Last, First, Middle)

_____
Date of Birth

_____
Social Security Number

_____
Patient's Address

_____
City, State, Zip Code

_____
Phone Number

The information authorized to release may include information which may be considered a communicable or venereal disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

This form is in compliance with state as well as federal laws and regulations. Treatment services are not contingent upon or influenced by the consumer's decision to permit the information release.

Information released should be sent to
Wilson Psychological Associates
417 E Silas Street
Bartlesville, OK 74003
Telephone (918) 337-6050
Fax (918) 337-6061

I hereby authorize the release of confidential information to the following: _____
(provider's name)

_____
Name & Title of the person and/or organization

I would like the following protected health information released:
___Intake Assessment ___Progress Notes ___Consult Note ___Substance Abuse Diagnosis ___Psychological Assessment ___Child Abuse and/or Neglect ___Sexually Transmitted Disease ___HIV/AIDS Information ___Sexual Abuse ___Abuse of an Adult with Disability ___Mental Illness/Development Disability

For the following purpose and that purpose only:
___Continued Treatment ___Personal ___ Other (Specify)
_____

This consent is allowed to be acted upon up to one year from the date of signature, unless a shorter time is specified by the patient or their representative. This authorization will remain in effect until the _____ day of _____, 20____ or until the following event occurs_____.

I understand this authorization is subject to revocation by me at any time expect to the extent that action has already been taken in reliance on it. In order to revoke this authorization, I understand that I must make this known to the provider or office of the provider, in written form as soon as this request is desired. With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity, and release WPA, its agents and employees from any liability in connections with the release of information contained therein. I understand that I may at any time make a written request to inspect and/or obtain a copy of my health information and that WPA will, within 45 days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any) and my instructions as to how and to whom I may register a complaint regarding the denial.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my protected health information. By my signature, I hereby knowingly and voluntarily authorize WPA to use or disclose my health information in the manner described above.

_____
Patient Signature (if patient is unable to sign, indicate reason) Date

_____
Parent/Guardian/Other Legal Representative Date
(Provide copy of legal document and specify relationship to patient).

_____
Witness (witness signature required for release of information about a mental illness)