Fishers Youth Counseling and Psychiatry
Amy S. Johnson, Psy.D., HSPP
11978 Fishers Crossing Drive
Fishers, IN 46038
Phone 317.774.3187

AUTHORIZATION FOR RELEASE OF INFORMATION

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

Patient Name: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip: _____

I authorize Amy S. Johnson, Psy.D, HSPP to release information to / obtain information from:

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: ( ) _____ Fax: ( ) _____

Information to be disclosed:

☐ Dates of Service ☐ Educational Recommendations ☐ Clinical Impressions
☐ Medical Record ☐ Discharge Summary ☐ Other: _____

I am requesting my psychologist to release this information for the following reasons:

☐ At the request of the individual ☐ Other: _____

This authorization shall remain in effect until (date)_____ or until (event)_____

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action 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 Guardian / Date Relationship to Patient

_____ _____
Patient / Date Witness / Date