MURPHY • URBAN
& ASSOCIATES
PSYCHOLOGICAL SERVICES

CONSENT FOR RELEASE / EXCHANGE OF INFORMATION

Patient Name: _____ Organization/Person: _____

Address: _____ Address: _____

_____ _____

Date of Birth: _____ _____

I authorize Murphy, Urban & Associates Psychological Services and its employees to release and/or exchange protected health information with the organization/person designated above. Information that may be released will include:

Medical Records	___	Psychological Assessment	___
Psychological Records	___	Drug & Alcohol Treatment	___
Treatment Plans	___	Discharge Summary	___
School Records	___	Verbal Exchanges	___

I understand the purpose(s) to be for:

At the Request of the Patient	___	Treatment Planning	___
Diagnosis and Evaluation	___	Continuation of Care	___

I understand that I may withdraw this consent at anytime by sending written notification to the office of Murphy, Urban & Associates. However, any revocation does not cover information already released by Murphy, Urban & Associates 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 the provision of services may not be made contingent upon the signing of this authorization, unless the psychological services are provided 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 the information and no longer protected by the HIPAA Privacy Rule.

This authorization will remain in effect for 180 days or until otherwise specified:
_____

_____ _____ _____

Signature of Client, Parent/Legal Guardian | Date | Signature of Witness

A Typed Name Will Serve as a Signature