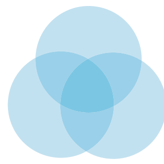


United Psychological
SERVICES

Release of Information

Patient's Name: ______________________________ Birthdate: _______________________

I hereby freely and voluntarily authorize a mutual release of protected healthcare information between the following professionals:

Person Releasing Information:

Name: United Psychological Services

Address:47818 Van Dyke Ave.

City: Shelby Township, MI 48317

Phone: 586-323-3620

Fax: 586-323-3568

Person Receiving Information:

Name: ____

Address: ______________________________________

City: ____

Phone: _______________________________________

Fax: ____

Person Releasing Information:

Name: ____

Address: ______________________________________

City: ____

Phone: _______________________________________

Fax: ____

Person Receiving Information:

Name: United Psychological Services

Address: 47818 Van Dyke

City: Shelby Township

Phone: 586-323-3620

Fax: 586-323-3568

Information to be released:

☐ Psychological Evaluation ☐ Treatment Plan ☐ Therapy Notes ☐ Medication Reviews

☐ Complete Records ☐ Psychological Screening ☐ Diagnosis ☐ Psychological Test Report(s)

☐ Phone Conversation ________________ ☐ Other: ____

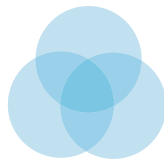
Purpose of disclosure:

☐ Insurance Matter ☐ Academic Matters ☐ Legal Matters ☐ Patient/Guardian Request

☐ Progress Update ☐ Referral for Services ☐ Coordination/Continuation of Care

☐ Other (explain): ____

See Reverse to Complete



United Psychological
SERVICES

- I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law.

- I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations.

- I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the federal HIPAA law.

- I understand that I have the right to revoke this authorization at any time by giving written notice to United Psychological Services, except to the extent that action has already been taken in reliance on it.

- I understand that I am providing my consent to receive password protected electronic information from United Psychological Services via email.

- If not previously revoked by me in writing, this Authorization is effective on this date and will expire one (1) year following discharge from treatment.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Witnessed By Date