VALLEY PSYCHOLOGICAL ASSOCIATES
VALLEY NEUROPSYCHOLOGY GROUP
AUTHORIZATION TO RELEASE INFORMATION

Name: _____ **Date of Birth:** _____

Address: (Including Zip Code) _____

Telephone Number: (Including Area Code) _____

□ I authorize Valley Psychological Associates to disclose the above individual's mental health information to:

Name: _____
Address: _____
Phone No: _____ **Fax No:** _____

(You must include the name, address, and the phone number of the person(s) or organization(s) receiving the information. If additional person(s) or organizations(s) are being authorized please list the name address and phone number on the back of this form.)

Description of the information to be disclosed: (If more space is needed to describe the information, please use the back of this form)

- **□ All claims and appeals** **□ Billing**
- **□ Specific claims (specify date(s) of service, claim number(s), etc)** _____
- **□ Other: (please specify)** _____
  _____

Purpose of Disclosure: (Please describe the purpose of this disclosure)

_____
_____

Section II. I understand that my specific authorization is needed to release my information pertaining to the items listed below. By initialing, I authorize

Mental Health Clinical Information _____ **(initials)**
Psychotherapy Notes _____**(initials)**

_____

Expiration and Revocation: An expiration date or event must be completed or checked)\
□ This specific date _____/_____/_____
□ The occurrence of the following event _____

Right to Revoke: You may revoke this authorization at any time. Contact Valley Psychological Associates for further instructions. Your revocation of this authorization will not affect any action we take before we receive your notice of revocation.

Personal Representative Information: Complete this section if a personal representative is authorizing disclosure of the member's information. .

Name: _____
Relationship to the Patient: _____
Address: (including Zip Code) _____
Telephone Number: (including Area Code): _____

Signature/Date: The member or member's personal representative must sign and date this form for it to be processed.
I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ **Date:** _____

□ Please check (√) this box if you would like to receive a copy of this form.