Shelby Psychological Services
1940 Highway 33, Suite A
Pelham, Alabama 35124
Phone: (205) 664-4010 Fax: (205) 664-9928

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION

Client's Name _____ **DOB** _____

My permission is granted to (*circle one*) Dr. Gaye Vance – Dr. Ellen Spence – Leska Meeler, LPC – Emily Tucker, LPC – Joanna Milkay, NCC/LPC-S – Amy Ray, M-Ed/LPC/NCC – to exchange information with:

_____

(*Name, title & phone/fax # of person you are permitting Shelby Psychological Services to exchange information with*)

The following information may be included in this exchange (*check all that apply*):

____ Clinical Intake
____ Consultation
____ Diagnosis
____ Medication Rx
____ Psychological Evaluation
____ Teacher's observations, progress testing; achievement scores
____ Emergency Notification
____ Treatment Plan/Outpatient treatment requests
____ Dates of Service

The purpose of this disclosure is (*check all that apply*):

____ to facilitate evaluation and treatment
____ for legal purposes
____ for other _____
____ for disability determination
____ for insurance purposes

This authorization will be valid for a period of one (1) year unless it is revoked prior to that time.

I hereby release _____(*provider circled above*) from any and all liabilities arising from but not limited to the laws of the State of Alabama and/or any other states, related to the disclosure of confidential or privileged information.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the SPS address. However, your revocation will not be effective to the extent that SPS has 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/counselor generally may not condition services upon my signing an authorization unless the 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 re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X_____ **Date** _____

Signature of: ☐ Patient ☐ Parent ☐ Guardian ☐ Legal Representative

X_____ **Date** _____

Witness Signature