EVAN MEHLMAN, PSY.D. & ASSOCIATES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PSYCHOLOGICAL RECORDS AND PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

_____ This authorization is valid for _____ days.

_____ This authorization is valid from now until 120 days following the termination of therapy o rclosure of my case or file with Evan Mehlman, Psy.D. & Associates.

You have the right to revoke this authorization in writing at any time by sending such written notification to our office. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurnace coverage and the insurer has a legal right to contest a claim.

By singing below you agree to the release of the above listed information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. You are indicating that you understand that Evan Mehlman, Psy.D. & Associates 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, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

_____

Signature of Patient or Authorized Representative

_____ _____

Printed Name of Signer Date

_____ _____

Witness Date

If the authorization signed by a personal representative of the patient, a description of such representative's authority to act for the patient must provided

ATIENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED:

If you have received this information in error please contact our office as soon as possible to arrange for the return of the received material. This information may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed by law.

Evan Mehlman, Psy.D. Associates
2883 Executive Park Drive Ste 102 Weston, FL 33331.
Ph: 954-384-1117 • Fax: 954-384-1163