Lunden Psychological Services, Inc.

Authorization to Release Information:

To release information to a Primary Care Physician or other Physician please complete a **'PCP Release'** form.

Due to HIPAA regulations governing Protected Healthcare Information we are unable to share any information (including billing and scheduling) with anyone (including family members) without written authorization from the patient.

_____ _____ _____

Name of Patient (Last, First, MI) | Patient's Social Security # | Patient's Date of Birth

1. Please check one of the following:

☐ **I DO NOT** wish to release my information to anyone at this time. *(Please skip to section 5)*

☐ **I DO** wish to release information. *(Please complete all sections)*

I authorize Dr. Lunden of Lunden Psychological Services to release information to:

Name:_____

Relationship to Patient:_____

Street Address:_____

City, State, Zip:_____

Phone: (_____)_____

Fax: (_____)_____

I authorize Dr. Lunden of Lunden Psychological Services to obtain information from:

Name:_____

Relationship to Patient:_____

Street Address:_____

City, State, Zip:_____

Phone: (_____)_____

Fax: (_____)_____

2. Purpose of Request *(Check all that apply)***:** ☐ Healthcare ☐ Insurance Coverage ☐ Personal

☐ Other:_____

3. Type of Information: Information may be released verbally, in writing, photocopied, by fax, email, or mail, unless the patient indicates otherwise. *(Check all that apply)*

☐ My Entire Record ☐ Billing Information ☐ Scheduling Information

☐ Diagnoses/Treatment Plan ☐ Progress Report of Treatment ☐ Testing Results/Report

☐ Substance Abuse Evaluation ☐ Other: *(Please specify)*_____

4. Timeframe Authorized: ☐ One-time authorization will expire once the requested information has been released/received. ☐ One year from this date ☐ Other:_____

5. Patient Authorization: I understand this authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization. My refusal to release my record(s) will not affect my ability to obtain treatment. If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations this information could be re-disclosed. Medical records not sent to another provider or physician will be subject to a records fee of $.50 per page.

_____ _____ _____ _____

Signature of Patient/Responsible Party | **Date** | **Printed Name** *(Last, First, MI)* | **Relationship to Pt.**