HIPAA Release of Psychological Assessment/Treatment Information

I, _____ authorize EmergeOrtho and Leslie (Les) Phillips, Ph.D to release verbally or in writing my protected health information including psychological/behavioral health assessment and treatment records to the persons/offices/entities designated below.

I likewise agree that Dr. Phillips may discuss my treatment with these parties as he deems necessary in my care.

Finally, I agree to allow heath care providers/persons/offices/entities listed below to release Dr. Phillips and EmergeOrtho the records of their treatment of me, including records of medical care, psychological/psychiatric care and substance abuse/addiction care.

____ (initial) _____(healthcare provider/person/entity name)

Address:_____

Phone: _____ Fax: _____

____ (initial) _____(healthcare provider/person/entity name)

Address:_____

Phone: _____ Fax: _____

Expiration Date of Authorization: One year from signature date below unless otherwise terminated.

Right to Revoke or Terminate: I may revoke or terminate this release at any time by notifying Dr. Phillips or EmergeOrtho in writing of my desire to revoke the release. I understand that any information already released or action taken prior to this termination cannot be reversed, and such my revocation will not affect such actions.

Signature: _____ Date: _____