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Request /Authorization to Release Confidential Records and Information to a Health Insurer or Other Third-party Payer

A. I hereby give authorization for Dr. Heather M. Berberet to release information from the patient's/my records maintained while the patient/I ☐ am being treated by her currently ☐ was treated by her during _____ or from _____ to _____.

B. The information to be disclosed is marked with an "X" in the boxes below.

☐ Psychological evaluation(s) or testing records, and behavioral observations or checklists by any staff member or by the patient/myself
☐ Treatment plans, recovery plans, aftercare plans
☐ Admission and discharge summaries
☐ Information about imapairments caused by the patient's condition.
☐ Billing records
☐ Social histories, assessments with diagnoses, prognoses, recommendations, and all similar documents
☐ Academic or educational records
☐ Achievement and other tests' results
☐ A letter containing treatment(s) dates and progress summary.
☐ HIV-related information and drug and alcohol information contained in these records will not be released under this consent unless indicated here: ☐ Consent to release HIV-related is given. ☐ Other: _____

C. I affirm to agreements in this document. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request. This information is to be sent to the third-party payer or its agents named above, and is needed for the receiving health insurance benefits, reimbursements, payments for related services, or decisions.

D. I understand that, by law, I need not consent to the release of this information. This information is not required for my/the patient's treatment. However, I willingly choose to release it for the purpose(s) specified above. I understand that I may revoke this release at any time within 90 days, except to the extant that action has been taken in reliance on my consent.

E. Also, please note the following points:

a. This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (42 C. F.R. Part 2, Section 2.31(a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.
b. This is strictly confidential material and is for the information of only persons who are professionally capable of understanding, appreciating, and acting upon it according to their specific and advanced professional training in the mental health field. No responsibility can be accepted by the provider or author of these records if this material is made available to any other person or persons who lack such training, or who would not treat it in a professionally responsible manner, or who otherwise should not have access to it, *including the patient.*
c. Redisclosure or retransfer of these records is expressly prohibited..
d. Federal and state rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

F. Assignment of health insurance benefits: My signature below authorizes the payment, directly to the above-named provider, of benefits payable under my policy. I understand that such payments will be credited to my account with this provider. I further understand that I am financially responsible to this provider for charges not covered or reimbursed by my policy, up to provider's standard fee.

G. For Medicare patients only: I request that payment of authorizes benefits be made to the provider listed above on my behalf. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine those benefits or the benefits payable for related services.

H. A photocopy of this release is to be considered as valid as the original.

_____ _____ _____
Signature of client Printed Name Date

_____ _____ _____
Signature of parent/guardian Printed name Date

I, a mental health professional, have discussed the issues above with the patient and/or the patient's parent/guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Heather M. Berberet, Psy.D. Date