



Psychological Counseling Services, Ltd.

Intensive Steps to Health and Wholeness

7530 East Angus • Scottsdale, Arizona 85251 • 480-947-5739 • pcs@pcsearle.com

Authorization Form

480-946-7795 Fax

This form, when completed and signed by you, authorizes Psychological Counseling Services, Ltd. (PCS) to release and/or request protected health information from your clinical record to the person you designate.

Re: Client/Patient Name _____	Date of Birth _____
Address _____	City _____ State _____ Zip Code _____
Phone # _____	

Name of requesting PCS Therapist: _____

I authorize Psychological Counseling Services, Ltd. to release- Please initial this section where appropriate:

- Psychotherapy Notes
- Telephone Contact/Consultation
- Psychological Exam and/or Testing Results
- Treatment Summary
- Thank You For Referral Letter/Call
- Medical Records
- PHI Only
- Other (Please be specific and detailed about your request below:)

This information should only be released TO OR FROM: (ONE PERSON/ORGANIZATION PER FORM)

Name of person, party, or agency _____		
Address _____	City _____	State/ Zip Code _____
Telephone Number _____	Fax Number _____	Email Address _____

This authorization shall remain in effect until _____ or one year from the date signed or until: _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to PCS. However, your revocation will not be effective to the extent that PCS 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 PCS and my psychotherapist 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 and no longer protected by the HIPAA Privacy Rule.

<input checked="" type="checkbox"/> Signature of Self, Parent, or Guardian _____	<input checked="" type="checkbox"/> Printed Name _____	<input checked="" type="checkbox"/> Date signed _____
Signature of Self, Parent, or Guardian _____	Printed Name _____	Date signed _____

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