PLEASE FILL OUT SECTION I and/or II, or III

SECTION I: Some insurance companies request that I coordinate care with your primary care physician. Additionally, if your primary care physician referred you to me, it cam be helpful for the physician to have basic information about your treatment in order to coordinate care. This form, when completed and signed by you authorizes me to release protected information from your clinical record to your primary care physician.

I authorize Amy McNulty, Ph.D., LCSW to release

Date of initial session
Information regarding my symptoms and basis medication needs
Notification of how often I am meeting with Dr. McNulty
Other:

This information should only be released to (name and address of primary care physician.):

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____ or until (fill in an event that relates to the individual of the purpose of the use or disclosure).

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

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purposes of creating health information for a third party.

I understand that the information used or disclosed pursuant to the authorization my be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient _____ Date_____

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.

SECTION II: If there is a doctor, psychiatrist, former therapist, teacher, parent, etc. that you feel would be important for me to receive or give information to, please indicate below. This form, when completed and signed by you, authorizes me to release or obtain protected information from your clinical record to or from the person you designate.

I authorize _____(Name of person) to release (Provide description of the information that you want disclosed.):

This information should only be released to (name and address of person to whom the information is to be released). (If released to me, write Amy McNulty, Ph.D.,309 South Sharon Amity Road, Suite 304, Charlotte, NC 29211.)

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____ or until (fill in an event that relates to the individual of the purpose of the use or disclosure).

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

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I understand that the 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.

_____ _____

Signature of Patient Date

_____

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.

SECTION III: If you do not want Dr. McNulty to exchange information with anyone, please fill out this section.

_____

Signature of Patient Date