Hollywood
Psychology
Center

954-981-8200 *tel* 954-272-8043 *fax*

Authorization of Release of Protected Health Information

1. PATIENT INFORMATION

Patient Last Name_____ First Name_____Middle Initial____ Date of Birth_____

Patients Address_____Email_____
Street City State Zip Code

Patients Home Phone_____Work Phone_____Cell Phone_____

2. RECIPIENT AUTHORIZATION

I, _____, do hereby authorize ***Hollywood Psychology Center and/or its Providers,***
Patient Name or Representative ***(Fax # 954-727-8043 Phone# 954-981-8200)***
to _____ **RELEASE** _____**OBTAIN** a copy of my mental health/medical records (and/or verbal communication) to/from the person/provider or facility below.

_____Phone _____Fax_____
Name
Address_____
Street City State Zip Code

3. INFORMATION TO BE RELEASED/OBTAINED

☐ Psychotherapy Notes/Initial evaluation ☐ Bariatric Evaluation ☐ Drug/Alcohol treatment ☐ Neuropsychological testing

☐ Other (please be specific)_____

4. PATIENTS RIGHTS AND PRIVACY

- I understand that I may revoke this authorization by providing a written statement to ***Hollywood Psychology Center***, except to the extent that ***Hollywood Psychology Center*** has already completed action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed to the receipt(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release Hollywood Psychology Center from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for the period of six months, and it automatically expires six months after the date this form is executed.

5. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____
Signature *Date*

Personal Representative:_____
Print name *Relationship*

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal authority for signing: ☐ Parent ☐ Legal guardian ☐ Next of kin of deceased