Kids On UP Psychotherapy
101 Conner Drive, Suite 203; Chapel Hill, NC 27514
Telephone: (919) 240-5548 **Fax: (919) 525-1900**

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, ____, authorize Kids On UP Psychotherapy
Print name of patient/client
to release and/or obtain the following PHI (***initial** beside item)*

[ ] My entire record [ ] Summary of assessment/treatment
[ ] Testing report [ ] Information needed to file insurance
[ ] HIV/Aids [ ] Substance abuse
****[ ] Coordination of care** [ ] Other

This information should only be released to and/or obtained from:

____

Phone: ______________________ Fax: _______________________ Email: ___________________________

I am requesting this release of information for the following reason(s) (***initial** beside item*)

[ ] At my request [ ] Legal consultation
[ ] Filing insurance claims [ ] Transfer of care
****[ ] Coordination of care** [ ] Other:

This authorization shall remain in effect until __________________________ (up to 1 year from authorization)

OR

[ ] I decline authorization

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Kids On Up Psychotherapy. However, I understand that any revocation will not be effective to the extent that Kids On Up Psychotherapy 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 Kids On Up Psychotherapy generally may not condition psychological or psychiatric services upon -my signing an authorization unless the 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 my information and no longer protected by the HIPAA Privacy Rule

____ _______________
Signature of client or authorized guardian/representative (indicate relationship) *Date*

Coordination of care with primary care providers is always requested