The office of
Thomas E. Thorsheim, Ph.D.
Incorporated
Licensed Psychologist
45 Greenland Drive, Greenville, SC 29615
Tel: 864-421-0098 *I* Fax: 864-421-0099

Provider: Melanie M. Albers, PhD (Licensed Psychologist)

Request/Authorization to Release Protected Health Information

DO YOU WISH TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM I - YOUR PROVIDER - MAY DISCUSS YOUR TREATMENT/MEDICAL CONDITION? IF SO, SPECIFY WHOM BELOW.

This form, when completed and signed by you, authorizes me and my office to release protected information about you from your clinical record to the person or people you designate. It also permits us to obtain information from those individuals and/or institutions you designate. By signing, you attest that you have had explained to you and fully understand this request/authorization to release and obtain records and information, including the nature of the records, their contents, and the consequences and implications of their release or acquisition.

I,_____, authorize my psychologist, Melanie Albers, Ph.D. or the clinical staff of Thomas Thorsheim, PhD, Inc. to release or obtain the following information pertaining to _____.
(insert patient name above)

[Check all that apply and cross out all other options]

- o Psychological evaluation
- o Progress notes
- o Summary of clinical record
- o All information
- o Other _____

This information should only be released to or obtained from:

[Check all that apply and cross out all other options]

- o My physician
- o My attorney
- o My previous therapist
- o Family member
- o Other_____

Name, address, and/or telephone number of person/people to whom information is to be released:

_____

_____

_____

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Request/Authorization to Release Protected Health Information-Continued

Provider: Melanie Albers, PhD (Licensed Psychologist)

I am requesting that Dr. Albers release this information for the following reasons: ("'at the request of the individual" is all that is required if you are my client and you do not have a more specific purpose")

AT THE REQUEST OF THE INDIVIDUAL/OTHER REASON:_____

_____

This authorization shall remain in effect until you request otherwise or (in the event that you do not revoke it), it shall remain in effect for 2 years from date of signature.

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 insurer has a legal right to contest a claim.

I understand that Dr. Albers 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 re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

SIGNED:_____ DATE:_____