HALLOWELL
SAN FRANCISCO

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Release of Information Authorization

Patient Name: _____
Date of Birth: _____
Street Address: _____
City, Sate & ZIP: _____
Phone/Email: _____

I hereby authorize the Hallowell Center to (please check ALL that apply):

☐ Release records to self or legal guardian

***PLEASE NOTE:* based on HIPAA guidelines it can take 2-4 weeks to fully review and send your medical records for self-release.**

☐ Release all information checked to the individual/party listed below

***information to be released:**

☐ Verbal Communication
☐ Email Communication
☐ Neuropsychology Reports
☐ Encounter Note(s) Rating
☐ Scales
☐ Summary Letter of Treatment
☐ Medication Information
☐ Other(please specify) _____

☐ Two-Way communication between the Hallowell Center and the individual/party listed below (e.g. parent, spouse, school, another provider, etc.).

Name: _____
Relationship: _____
Street Address: _____
City, Sate & ZIP: _____
Phone: _____

For the Purpose of (Please check one)

☐ Continued Treatment
☐ Legal Review
☐ Medication Refill Facilitation
☐ Other (please specify) _____
☐ Insurance purpose
☐ Personal review of information
☐ Scheduling Appointments

PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign this form in order to receive treatment
- I understand that I may revoke this authorization by providing a written statement to the Hallowell Center, except to the extent that it has already been completed.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the Hallowell 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 a period of one year, and it automatically expires one year after the date this form is executed

_____ Signature

_____ Date

_____ Printed Name

_____ Relationship to Patient