Endeavor Psychology & Consulting

Krista Bacon, Psy.D.

Clinical & Forensic Psychologist in Vancouver, WA

4001 Main Street, Suite 218
Vancouver, WA 98663
(360) 777-6915
drbacon@endeavor-psych.com
www.endeavor-psych.com

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient Name: ______________________________ Date of Birth: ________________________

I hereby authorize Endeavor Psychology & Consulting, Krista Bacon, Psy.D., to receive and/or send my protected healthcare information from/to the following individual or organization:

Name: ______________________________ Attn: ________________________

Address: ____________________________________

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Phone: ________________________

Fax: ______________________________

__________________I understand that Dr. Bacon will only share the minimum information required about me and my records with anyone for whom I provide a release.

__________________I authorize the release of my personal information for purposes of coordinating care for services I am seeking.

__________________I authorize release of my personal information and entire medical record including, but not limited to, history and physical exams, problem list, progress notes, summary reports, consultations, nursing notes, lab reports, and medication records.

__________________I specifically authorize release of specially protected healthcare information including mental health evaluation and treatment records, reports of psychological/neuropsychological assessment, information related to drug or alcohol abuse diagnosis or treatment, and information about HIV/AIDS/sexually transmitted diseases.

__________________I authorize release of records for all dates of services unless otherwise specified. This authorization is valid for one year from the signed date unless otherwise specified.

__________________I understand that release of information is to aid in the evaluation of my current

psychological functioning.

__________________I understand that I may refuse to sign this authorization.

__________________I understand that I may revoke authorization in writing by sending a letter to Dr. Bacon.

__________________I understand that such a revocation will not be effective for records already released by my prior authorization.

__________________I understand that information disclosed could be subject to re-disclosure and may not be protected by federal privacy laws or regulations.

__________________I acknowledge that I received a copy of this authorization.

Do not release the following information (optional):

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Please Note: By signing the space below, you are saying that you agree and understand that this electronic signature is the legal equivalent of your manual/handwritten signature and you consent to be legally bound to this agreement.

______________________________	______________________________	______________
Parent/Guardian (If client is younger than 18 years old) Full Name	Parent/Guardian (If client is younger than 18 years old) Signature	Date

______________________________	______________
Client Signature	Date

______________________________	______________
Provider Signature	Date