MEDICAL PSYCHOLOGY ASSOCIATES

Signature of this form gives authorization and disclosure of Protected Health Information

Patient Name D.O.B. Phone number

Street Address City State Zip

Please check one ☐ Obtain Information From ☐ Release Information To ☐ Exchange Information With

Authorizes:

Medical Psychology Associates
6110 N Port Washington Road
Glendale, Wisconsin
Phone: 414-962-1000
Fax: 414-963-6866

Name of Person or Organization

Street Address

City, State, Zip

Phone Number Fax Number

Type of Information to be Disclosed:

____ Psychiatric Evaluation
____ Psychological Evaluation
____ Medical Information
____ Alcohol/Drug Abuse
____ School Records/Teacher Observations
____ Office Notes
____ Information Required to Bill Third Party for Services
____ Other ______________________________

Purpose of Information:

____ To Facilitate Counseling/Therapy
____ To Facilitate Educational Planning
____ To Facilitate Psychological Evaluation
____ Payment of Third Party/Insurance Claim
____ Legal Investigation
____ Coordinate Care with Medical Provider
____ Other ________________________

- Re-disclosure Notice: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, the health information disclosed as a result of this information may no longer be protected by the Federal privacy standards and my health information may be re-disclosed by such person(s) and/or organization(s) without obtaining my authorization.
- Revocation of Authorization: I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency I authorized to release information.
- I have a right to inspect and receive a copy of the records disclosed. I have a right to receive a copy of the authorization. I have a right to refuse to sign the authorization. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization.
- If this authorization is for the purpose of filing an insurance claim, all benefits will be paid directly to Medical Psychology Associates.
- A fee may be charged for copying costs.

This Authorization is valid for one year from the date I sign this Authorization unless indicated otherwise below.

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I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Client Signature Date Witness Date

Signature of Client's Legal Representative Date Relationship to Client