Better Being
Psychological Services, Inc.
1151 Dove Street, Suite 105, Newport Beach, CA 92660
Office: 949-706-4889; website: www.betterbeingpsych.com

# Authorization for Release of Protected Health Information (PHI)

Client's Name: _____ DOB: _____

I, _____, authorize Better Being Psychological Services to:

___Release ___Obtain from ___Exchange

with:

Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

the information pertaining to myself:

___ Treatment summary ___Intake/history ___Diagnosis ___Psychological testing

___ Psychiatric evaluation/medication history ___Dates of treatment attendance

___ Other (specify): _____

including the below information, which I understand I must specifically authorize by marking the line below:

___ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis, or treatment (42 C.F.R 2.34 and 2.35).

for the purpose of:

___ Evaluation, assessment, and/or coordination of treatment efforts

___ Other (specify): _____

**Duration of Authorization:** I understand that this authorization is valid only for the purpose, information, agencies, and persons cited above. Unless otherwise revoked, this authorization

will **expire in one (1) year** or on the following earlier date, condition, or event:

_____

**Re-disclosure:** I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I understand that my Protected Health Information (PHI) that is used or disclosed under this authorization may be subject to re-disclosure by the recipient, and the privacy of my PHI may no longer be protected under these guidelines if they are not a health care provider covered by state or federal rules.

**Revocation of Authorization:** I understand that this authorization is voluntary and may be revoked at any time, except to the extent that Better Being Psychological Services, Inc. has already taken action upon it. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned based on this authorization or revocation of the authorization unless otherwise allowed by law.

Client's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____