HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF PSYCHOLOGICAL RECORDS/PSYCHOTHERAPY NOTES
PURSUANT TO 45 CFR 164.508(a)(2)

Name or specific identification of the provider, person(s), or class of persons, authorized to make the requested disclosure:

_____

_____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

I authorize the disclosure of all psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition, including substance abuse (including drug and alcohol information) for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information, including the following:

All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, therapy notes, office and doctor's handwritten notes, records received by other physicians, pharmacy and prescription records and billing records.

This authorization is given in compliance with 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I authorize you to release the protected health information to:

Gibbons P.C.
One Gateway Center
Newark, NJ 07102-5310

The Marker Group, Inc.
13105 Northwest Freeway, Suite 300
Houston, TX 77040

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.

I acknowledge the right to revoke this authorization by writing to Gibbons P.C. or the Marker Group, Inc. at the above referenced addresses. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.

I acknowledge the right to inspect the material to be released.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires two years from the date below.

Signature: _____ Date: _____
Relationship to the person who is the subject of the records:
Self: _____ Other: _____
Describe authority: _____