DONALD W. SWAN, Psy.D.

LICENSED PSYCHOLOGIST

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Authorization to Use and Disclose Protected Health Information

This form is used to provide authorization for use or disclosure of your protected health information as required by law and Dr. Swan's policies and procedures. Do not sign this authorization unless it is completed in full and in your best interests. You may have a copy of this document if you request.

By **initialing** the spaces below, I, ____(______) ,

D.O.B. ______________ SS# _____________________ hereby authorize Donald W. Swan, PsyD to:

____ release information to: ____ obtain information from: ____ exchange information verbally with:

Contact Person: ________________________________ Agency: _________________________________

Address: ____

City State Zip

Phone: ____ Fax: _________________________________

This authorization for release extends to the care and treatment the client received during:

____ For all dates of services
____ For service between _____________ and ______________

For the following purposes:

____ Evaluation, assessment, and/or treatment
____ Ongoing coordination of treatment
____ Other ____________________________________

Please initial each line of information to be included:

- □ ____ Treatment Plan or Summary
- □ ____ Psychological Evaluation / Reports
- □ ____ Chemical Dependency
- □ ____ Diagnoses
- □ ____ Mental Health Records
- □ ____ Psychotherapy notes
- □ ____ Psychosocial History
- □ ____ Test Results
- □ ____ Other: ________________
- □ ____ School Records
- □ ____ HIV or AIDS information
- □ ____ Medical / Hospital / Lab Evaluations

REQUIRED STATEMENTS:

If the person who receives your information is not a health care provider or insurer, the information may be subject to re-disclosure and no longer protected by federal regulations. Federal and state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

You do not need to sign this authorization. Your refusal to sign this will not affect your ability to obtain mental health or alcohol/drug services from Dr. Swan (unless your sole purpose for obtaining these services is to provide health information to someone else and the authorization is necessary to make that disclosure.)

This written authorization is subject to revocation in writing at any time, except to the extent that action has been taken. Any use or disclosure already made cannot be undone. If not earlier revoked, this consent shall expire 180 days from signing or ____________.

I have read this authorization and I understand it:

____ ______________________

Signature of client, parent or legal guardian Date signed

____ ______________________

Witness Date signed

updated 1/22/10