THE CENTER FOR INTERNET AND TECHNOLOGY ADDICTION
PLUG BACK INTO LIFE!©

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Authorization to Release/Obtain Information Form

This form when completed and signed by you, authorizes me/us to release protected information from your clinical record to the person you designate.

I authorize my Mental Health Provider, _____
Mental Health Provider's Name & Degree
and/or his or her administrative and clinical staff (cross out if not applicable) to _____ release _____obtain
(Please initial your request)

_____
Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.

_____

_____

This information should only be released to/obtained from:

_____

_____

I am requesting my Mental Health Provider to release this information for the following reasons:

_____
("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my Mental Health Provider generally may not condition psychological and/or medical services upon my signing an authorization unless the mental health/medical services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____
Signature of Parent/Guardian

_____
Print Name

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_____
Signature of Witness