Silber Psychological Services, P.A.

www.silberpsych.com

1004 Dresser Court, Suite 103
Raleigh, North Carolina 27609
Telephone: (919) 876-5658
Fax: (919) 790-1521

1340 S.E. Maynard Road, Suite 201
Cary, North Carolina 27511
Telephone: (919) 481-9012
Fax: (919) 481-9013

Authorization for Release or Exchange of Information

Patient Name: ____ Date of Birth: ____________ Phone No: ____________

Address:____
Street City State Zip

This form, when completed and signed by you, authorizes clinical and/or administration staff of Silber Psychological Services, P.A. to release, exchange, or obtain Protected Health Information (PHI) from person(s) you designate.

I authorize Silber Psychological Services, P.A. and their administrative and/or clinical staff to **release, exchange or obtain,** from the following: **(If more than one, please list on back)**

	Pediatrician/Physician	Psychiatrist/Therapist
1. Name	1.________________________	1.________________________
2. Address	2.________________________	2.________________________
3. City	3.________________________	3.________________________
4. State 5. Zip Code	4.________ 5. ____________	4.________ 5. ____________
6. Phone Number	6.________________________	6.________________________
7. Fax Number	7.________________________	7.________________________

	School	Other (Attorney, Agencies, etc.)
1. Name	1.________________________	1.________________________
2. Address	2.________________________	2.________________________
3. City	3.________________________	3.________________________
4. State 5. Zip Code	4.________ 5. ____________	4.________ 5. ____________
6. Phone Number	6.________________________	6.________________________
7. Fax Number	7.________________________	7.________________________

I may limit this exchange of information to: ______________________________________, otherwise only information related to coordination of care and treatment policy is exchanged.

This authorization is only for the limited purpose of obtaining from or releasing to, and discussing my case with these individuals or agencies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

I have the right to revoke this authorization at any time by sending a written notice to Silber Psychological Services, P.A. However, revocation will not be effective to the extent that action based on the consent has already taken place 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 information used or disclosed pursuant to the authorization is beyond the control of Silber Psychological Services and consequently may be subjected to re-disclosure by the recipient and no longer protected by HIPAA.

This authorization will expire in 365 days unless I elect an expiration date of: __________ Initial: __________

Sign:____ ☐Parent ☐Patient ☐Legal Representative

Witness:____ Date:____________________

(Please turn to page 2 *if needed*)

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Authorization for Release or Exchange of Information

Patient Name: ______________________ Date of Birth: __________ Phone No: __________

Address: ____
Street City State Zip

	Other	Other
1. Name	1.______	1.______
2. Address	2.______	2.______
3. City	3.______	3.______
4. State 5. Zip Code	4.______ 5. ______	4.______ 5. ______
6. Phone Number	6.______	6.______
7. Fax Number	7.______	7.______

	Other	Other
1. Name	1.______	1.______
2. Address	2.______	2.______
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4. State 5. Zip Code	4.______ 5. ______	4.______ 5. ______
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