RHYTHM PSYCHOLOGICAL SERVICES, LLC

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AUTHORIZATION FOR THE USE OF DISCLOSURE
OF PROTECTED HEALTH INFORMATION

_____ _____ _____
(Name) (Date of Birth) (Today's Date)

I hereby freely and voluntarily authorize Rhythm Psychological Services, LLC. to:
_____ Release/disclose records of my health information to:
_____ Obtain records of my health information from:

_____ ( )
(Individual, Facility, Organization) (Telephone Number)

_____ ( )
(Address) (Fax Number)

_____
(City, State, Zip)

The purpose for this disclosure is:

- ☐ To assist in funding
- ☐ To assist in treatment planning
- ☐ To keep the above informed of resident's progress
- ☐ Other (specify)_____
- ☐ To assist in education placement
- ☐ To coordinate discharge planning/placement

The information to be released/obtained included:

o Discharge Summary	o Treatment Plans	o Psychiatric Evaluation
o Lab, X-rays, EEG, EKG	o History and Physical	o Verbal exchange of information
o Psychological Testing	o Immunization Record	o Substance Abuse Treatment
o Educational Assessments/Testing/Evaluations and Records		
o Polygraph Summary	o Risk Assessment/ABEL	o Other (specify)_____

* Psychological, risk assessment, ABEL and polygraph reports are intended for trained professionals, preferably a psychologist or psychiatrist with expertise in the appropriate area. Raw data is not released unless required by law.

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not rediscover them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. This consent expires on (date):_____

_____ _____
Patient Signature *(Signature required if alcohol or drug treatment is involved)* Date

_____ _____
Parent/Guardian/If Authorized Representative (Describe: _____) Date

_____ _____
Witness Signature Date

*Drug/Alcohol records are protected by Federal confidentiality rules (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigation or prosecute any alcohol or drug abuse resident.