**Shannon Price Albarelli, Psy.D.**

**Clinical Psychologist**

**NJ License # 4764 / EIN # 45-3329462 / NPI # 1225268329**

**57 Union Place St. 212**

**Summit, NJ 07901**

**973-544-8067**

**Authorization to Use and Disclose Protected health information**

1. I am completing this form to allow the use and sharing of protected health information

about:

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. I authorize this person or organization: Dr. Shannon Albarelli, Psy.D.

To use or disclose the following information:

\_\_ Complete copy of treatment records, including dates of attendance, problem history, diagnosis, prognoses, level of functioning, treatment plans & recommendations as well as progress notes and other written records related to treatment

\_\_ Treatment summary only (dates of attendance, diagnosis, prognosis, level of functioning)

\_\_ Psychological evaluations, reports, or assessment results, and dates

\_\_ Billing records and dates of service

\_\_ Verbal communication

\_\_ Other

To this person or organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. The information will be used/disclosed for the following purposes:

 \_\_ Coordination of treatment with other providers

 \_\_ Transfers/Referrals

 \_\_ Billing/Insurance

 \_\_ Legal

 \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. I understand and agree that this Authorization will be valid for one year, until \_\_\_\_\_\_\_

I understand that after that date, no more of this information can be released unless I sign a new Authorization.

5. I understand that I can revoke or cancel this Authorization by sending a letter to Dr. Albarelli, supplying the released information. The letter revoking this Authorization will prevent any disclosures after the date the letter is received, but cannot change the fact that some information may have already been shared before that date.

6. I understand that my right to receive treatment and my eligibility for benefist may not be conditioned on my agreement to sign this Authorization.

7. I understand that if the person or organization that receives the released information is not a health care provider or a health plan covered by federal regulations, the information described above may be re-disclosed and no longer protected by those regulations.

8. I affirm that everything in this form that was not clear has been explained to me, and that I now understand all of it.

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Signature of client or his/her personal representative Date

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Printed name of client or personal representative Relationship to client

9. I, a psychologist, have discussed the issues above with the client and his/her personal representative. My observations of his/her behavior and response give me no reason to believe that this person is not fully competent to give informed and willing consent.

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Signature of professional Printed Name Date