

# 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: \_\_\_\_\_

# 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

### Other

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

### Other

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_ 5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

### Other

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

### Other

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_ 5. \_\_\_\_\_
6. \_\_\_\_\_
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: \_\_\_\_\_