MNCCTA
Minnesota Center for
Collaborative/Therapeutic Assessment

Request and Authorization for Release of Medical and Psychological Information

I authorize Raja M. David, PsyD, LP. LLC to use and disclose the specific protected health information described below regarding:

Name: _____ DOB: _____

as is necessary to_____ exchange information with, ____ release information to, and/or _____ obtain information from:

_____
Name of person or agency Street Address

_____
City/State/Zip Phone # Fax#

	Yes	No
Diagnostic assessment	_____	_____
Psychological evaluation	_____	_____
Treatment/case/progress notes	_____	_____
Discharge summary	_____	_____
Medical information	_____	_____
Verbal consultation	_____	_____
Legal/court information	_____	_____
Chemical health records*	_____	_____
Other: _____	_____	_____

The disclosure is for the purpose of: _____ OR Continuing care, such as evaluation, treatment and referral.

If this authorization is for use and disclosure or to allow another health care professional or entity to disclose information:

- Treatment cannot be denied if you refuse to sign this authorization;
- You have the right to inspect the protected health information (PHI) to be used or disclosed;
- You may refuse to sign this authorization; and,
- A copy of the signed authorization must be provided to you at your request.

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that the information already has been used or disclosed in reliance on this authorization. *Unless revoked earlier or otherwise indicated, this authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.*

By signing this authorization, you may be directing us to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners, health plans and other health care entities observe under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law. Therefore, Raja M. David, PsyD, LP, is released from any and all liability resulting from redisclosure.

_____
Signature of client(s) Date

* I understand that my alcohol and/or drug treatment records are protected under federal and state regulations (42 CFR Part 2 and ORS 430.399(5), 179.505) governing confidentiality of alcohol and drug treatment records, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

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