SHEILA A. MEGAN, PHD
Licensed Clinical Psychologist - NV Lic. #PY0500
542 Lander Street Reno, NV 89509-1551
775-786-0404 Fax: 775-337-9039
~www.sheilameganphd.com~

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL / PSYCHOTHERAPY RECORDS

(PLEASE PRINT)

_____ _____
Patient Name at the Time of Treatment Date of Birth

The undersigned hereby authorizes and requests this facility or _____, to provide:

☐ Physician ☐ Psychotherapist ☐ Insurance ($1.00 per page) ☐ Attorney ($1.00 per page)

☐ Other Purpose: _____

Name of Person, Organization to whom disclosure will be made: _____

I understand that the parties in receipt of these records may re-disclose my PHI (Protected Health Information) to persons or entities that are not subject to the HIPAA Privacy Regulations, resulting in my PHI no longer being protected by HIPAA regulations.

Signature:

_____

I would like the following information released: ☐ Only those items listed below:

_____ Intake Information _____ Progress Notes _____ Discharge Summary

_____ Record of Appointments _____ Diagnosis _____ Billing Records

_____ Psych Assessment Report _____ Summary of Treatment _____ History

_____ Other: _____

I specifically authorize release of information for the following treatments or procedures that are included in these records. (You must initial those items requested, or they will not be released with the above record.)

____ Drug/Alcohol Abuse Treatment ____ Psychological and Mental Health Treatment ____ Psychotherapy Notes

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. I understand that the revocation must be made in writing, and addressed to Sheila A. Megan, Ph.D. and delivered or mailed to: Sheila A Megan, PhD, 542 Lander Street, Reno, NV 89509.

This consent will automatically expire 90 days from the date signed. Furthermore, this consent will be revoked upon compliance of this request and will not serve any other future request. I reserve the right to withdraw, in writing, this authorization at any time.

_____ _____
Date Signature of Patient

_____ _____
Witness Signature of Legal Representative

_____ _____
Reason Patient Unable to Sign Relationship

*** * DUE TO CONFIDENTIALITY, WE ONLY FAX UNDER HIPAA GUIDELINES * ***