BAY AREA PSYCHOLOGICAL CONSULTANTS

Benshoof & Tallman P.A.

1417 N. Partin Drive, Suite One • Niceville, Florida 32578 • Telephone 850-729-0303 • Fax 850-729-0305

Individual Authorization - Request for Medical Records

I hereby knowingly authorize: _____

Phone: _____ Fax: _____

to ☐ send / ☐ receive the following information to/from **Bay Area Psychological Consultants**.

Check Provider**:**

☐ **Bonnie G. Benshoof**, PhD ☐ **Michael L. Tallman**, PsyD ☐ **Cayleigh Benny Harper**, PsyD
☐ **Codie A. Amos**, LMHC ☐ **Jordin E. Early,** LCSW ☐ **Angela M. McManus**, LCSW
☐ **Shari D. Adams**, LMHC ☐ **Jessica R. Myers**, LCSW ☐ **Jennifer E. Tallman,** LCSW

Check the appropriate boxes that describe the information to be released:

☐ All ☐ Progress Notes ☐ Psychiatric/Psychological Evaluation

☐ Treatment Summary /Recommendations ☐ Diagnostic Test Results ☐ Billing/Appointment Records

☐ Other _____

Purpose of the release

☐ Continuity of Care ☐ Legal Purpose ☐ Changing Providers ☐ Other _____

This authorization is in effect until (date/event):_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the above address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization 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 my psychologist/mental health counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient/Legal Guardian/Parent Date

_____ _____
Patient's Name Date of Birth Witness

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

*****NOTICE TO PARTY AUTHORIZED TO RECEIVE THIS INFORMATION*****

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE LAW. STATE LAW PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF SUCH INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM SUCH INFORMATION PERTAINS, OR AS OTHERWISE PERMITTED BY STATE LAW. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.