Bobbie G. Hopes, Ph.D.

Clinical/Forensic Psychologist

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Authorization to Use, Disclose or Release Health Information

Patient Name: (please print)_____

Social Security Number: _____

Telephone Number: _____ Date of Birth: _____

I authorize Name: _____Address:_____

_____Phone #: _____ Fax #:_____
to use, disclose, or release the following protected health information about the above named patient: (includes dates below)

___ history and physical ___ operative report
___ discharge summary ___ pathology report
___ laboratory results ___ x-ray imaging reports
___ progress notes ___ physician orders
___ consultation reports from (doctor's name) _____
___ entire record (excluding psychotherapy records if any exist)
___ psychotherapy records
___ other (specify what is to be used, disclosed, or released): _____
Treatment from (date) _____ to (date) _____
or ____all records.

2. I understand that the information to be disclosed may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services, and treatment or testing for alcohol or drug abuse.
3. I authorize disclosure of the above listed information to the following individual or organization: Bobbie G. Hopes, Ph.D.,6 South Second Street, Suite # 815, Hamilton, Ohio 45011
For the purpose of: Psychological Evaluation. **Information Due** _____
4. I understand that I have a right to cancel this authorization, in writing, at any time by presenting my written cancellation to the manager, Health Information Management, or other designated representative, at the specific entity. I understand that a cancellation will not apply to information that has already been released under this authorization. I understand the at the cancellation will not apply to my insurance company when the law gives my insurer the right to consent a claim under my policy number.
5. Unless I cancel it sooner, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization expires in six months from the date appearing at the bottom.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment. However, information will not be released to the above indicated individual or organization without my signature. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Hopes at 513-844-8440. I am to receive a copy of this signed authorization to keep for my records.

_____ _____ _____
Signature of Patient or Legal Representative Print Name Date

If signed by Legal Representative, relationship to patient: _____