DAMOUS PSYCHOLOGICAL SERVICES
218 D Street • South Charleston, West Virginia 25303 • Phone 304-720-3835 • Fax 304-720-3836

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

SOURCE: **Damous Psychological Services**
218 D Street
South Charleston, WV 25303

I hereby authorize the above-named source to:

☐ Obtain information from ☐ Release information to ☐ Correspond with

SOURCE: _____ Phone: _____

Address: _____ Fax: _____

Purpose of Release: _____

Information to be released:

_____ • Any and all pertinent psychological and/or medical information.

_____ • Report(s) of psychological evaluation; includes the results contained in the entire report and an interpretive letter of necessary information.

_____ • Recommendations only.

_____ • Other: _____

*This authorization will expire on _____.
(If no date is specified, this release will expire one year from date signed unless otherwise revoked.)

I acknowledge that I have the right to refuse to sign this authorization. Refusal to sign this authorization will NOT affect my ability to obtain treatment. When my information is used or disclosed in accordance to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time, which I may contact Damous Psychological Services to do so.

_____ / _____
Client Signature (Parent and Legal Guardian if under 18 years of age) *Date*

_____ / _____
Witness *Date*