

David A.  
Steinweg  
Ph.D.



**PSYCHOLOGICAL SERVICES, LLC**

■ 21403 Chagrin Boulevard, Suite 245, Beachwood, Ohio 44122  
■ Tel (216) 283-6852 ■ Email: david.steinweg@gmail.com  
■ Website: www.davidsteinweg.com

**RELEASE OF INFORMATION AUTHORIZATION**

This form is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your protected health information.

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Recipient:** This authorization gives David A. Steinweg, Ph.D., Psychological Services, LLC, my permission to obtain my protected health information from and/or disclose my protected health information to: \_\_\_\_\_

**Type of Information:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acknowledgement of Referral | <input type="checkbox"/> School Personnel Observations | <input type="checkbox"/> School Records          |
| <input type="checkbox"/> Diagnostic Assessment       | <input type="checkbox"/> Psychological Evaluation      | <input type="checkbox"/> Psychological Treatment |
| <input type="checkbox"/> Medical History             | <input type="checkbox"/> Psychiatric Treatment         | <input type="checkbox"/> Treatment Summary       |
| <input type="checkbox"/> Other: _____                |  |  |

**Limits to Authorization Release:** \_\_\_\_\_

**Purpose:** This authorization for disclosure is at the request of the individual

**Format:**  Verbal  Written  Fax  Email (please note that email may not be a secure format)  
 All of the above

**Expiration:** This authorization shall remain in effect  180 days from signature date  Until I revoke it

**I understand the following:**

- I hereby authorize David A. Steinweg, Ph.D., Psychological Services, LLC, to obtain/disclose the specific protected health information identified above to the person(s) identified above.
- I may inspect or copy the protected health information to be used or disclosed.
- I have the right to revoke this authorization, in writing, at any time, by sending such written notification to Dr. Steinweg's office at the address above. However, my revocation will not be effective to the extent that he has taken action in reliance on the authorization or this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- Dr. Steinweg may not condition psychological services upon my signing an authorization unless the psychological services are provided for the purpose of creating health information for a third party.
- I understand that there may be information in the record that relates to substance abuse, mental illness, or HIV/AIDS that is of a highly confidential nature.
- I understand that information used or disclosed through this authorization may be redisclosed by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Relationship:**  Self  Parent  Legal Guardian

**Date:** \_\_\_\_\_