David A. Steinweg Ph.D.

PSYCHOLOGICAL SERVICES, LLC

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

☐ Acknowledgement of Referral ☐ School Personnel Observations ☐ School Records
☐ Diagnostic Assessment ☐ Psychological Evaluation ☐ Psychological Treatment
☐ Medical History ☐ Psychiatric Treatment ☐ Treatment Summary
☐ 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:** _____