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

***Client Name*:** _____ **DOB:** _____

Recipient: I authorize David A. Steinweg, Ph.D., Psychological Services, LLC, to disclose to and/or obtain from:

_____ the following information:
(Insert Name of Person, Title of Person, or Name of Organization)

Type of Information to be Disclosed:

- ☐ Assessment
- ☐ Diagnosis
- ☐ Treatment Plan or Summary
- ☐ Current Treatment Update
- ☐ Progress in Treatment
- ☐ Presence/Participation in Treatment
- ☐ Educational Information
- ☐ Medical Information
- ☐ Psychiatric Treatment
- ☐ Information Requested by Insurance to Process Claim
- ☐ Other: _____

Limits to Authorization Release: _____

Purpose: This information may be used or disclosed in connection with mental health treatment, payment or healthcare operations. If the purpose is other than as specific above, please specify: _____

_____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to David Steinweg, Ph.D., Psychological Services, LLC, at 21403 Chagrin Blvd, Suite 245, Beachwood, OH 44122. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization shall remain in effect: ☐ Until the following date: _____
☐ 180 days from signature date ☐ Until I revoke it

Conditions: I further understand that David Steinweg, Ph.D., Psychological Services, LLC, will not condition my treatment on whether I give authorization for the requested disclosure. It has been explained to me that failure to sign this authorization may have the following consequences: _____

_____

Format: Unless you have specifically requested in writing that the disclosure be made in certain format, we reserve the right to disclose the information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____
Signature of Client Date

_____
Signature of Parent or Guardian Date