**Associates in Psychology & Therapy, Inc. (APT, Inc.)**



**East Hills Professional Center**

**5185 Route 60 East, Suite 32**

**Huntington, WV 25705**

**www.wvpsychologist.com**

**PH: (304) 302-0526 Fax: (304) 302-0527**

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| **Authorization for Release of Information** |

**Name:**  **Date:**

**Date of Birth:**

I hereby authorize Associates in Psychology & Therapy, Inc. (APT, Inc.) to send health information to :

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
|  |  |
| Phone: |  |
| Fax: |  |

I authorize Associates in Psychology & Therapy, Inc. (APT, Inc.) to release information from my medical records to any health care provider involved in my care and treatment. Associates in Psychology & Therapy, Inc. (APT, Inc.) may also release information to any person or organization liable for all or part of my charges, such as my insurance carrier, Medicare programs, any third-party payer, and my employer's workers' compensation carrier. I understand disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Associates in Psychology & Therapy, Inc. (APT, Inc.) is no longer responsible for the confidentiality of any information known or possessed by the payer.

**Scope of information to be released:**

* All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (please specify)

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* All information regarding care received by patient between the dates of \_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_
* All Alcohol or Drug Use Treatment
* Other Information (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |
| Signature of Patient or Legally Responsible Person |  | Name (Please print) |
|  |  |  |
| Relationship/Reason Why Patient Is Unable to Sign |  | Date |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Witness |  | Date |