Irby Psychological Services

Psychology · Counseling · Applied Behavior Analysis
Speech Therapy · Occupational Therapy · Physical Therapy

Southaven
5960 Getwell Rd Ste 212-D
Southaven, MS 38672

Clarksdale
134 Sunflower Ave
Clarksdale, MS 38614

662-228-0130 (Phone) · 678-868-2843 (Fax)
frontdesk@irbypsychservices.net · www.irbypsychservices.net

AUTHORIZATION TO DISCLOSE/OBTAIN PROTECTED HEALTH INFORMATION

A. Information – *This is the individual whose information will be released.* (Individuals over 18 years of age must complete their own form, except for legal Personal Representative situations.)

Client's Name(print):_____

Address (Street, City, State, and Zip Code): _____

Telephone Number:_____ E-Mail Address: _____

B. Authorized Party – *This is the person or organization who will receive/provide the Member's information.*

I authorize **Irby Psychological Services, LLC** to (check both for providers to have back-and-forth communication):

- ☐ **Obtain** the above Member's Protected Health Information **from**
- ☐ **Release** the above Member's Protected Health Information **to**

_____
(Name of other clinic/provider; complete one form per provider/clinic)

C. Information To Be Released – *If limiting disclosures, please describe.* ***Check one box only.***

- ☐ *ALL* information relating to provision or payment of healthcare benefits or services may be released.
- ☐ Other (please describe):_____

D. EXPIRATION AND REVOCATION - *When this Authorization will end.* ***Check one box only.***

- ☐ Six (6) months (This option will apply if no other expiration is specified.)
- ☐ On this specific date _____ or occurrence of this event: _____

Revocation: You may revoke this Authorization at any time by notification in writing.

E. PATIENT SIGNATURE – *Please sign and date below.*

This Authorization is voluntary and completed at my own request. I understand that if the person or organization I have authorized to receive the information is not subject to federal health information privacy laws, the information may be re-disclosed and no longer be protected by federal privacy laws. I understand that giving this Authorization is not a condition of enrollment in a health plan or eligibility for benefits. This Authorization is not valid unless completely filled out, signed and dated by the Client or by their legal Personal Representative.

_____ _____
Signature of Patient or Parent/Guardian Date
** If the Patient is a dependent minor child, the child's parent or legal guardian must sign this form.

F. PERSONAL REPRESENTATIVE INFORMATION – If you are signing this Authorization as the Person's Personal Representative, please complete this section and attach a copy of the legal document establishing this authority (except for parent of minor, dependent child).

Name of Personal Representative: _____
Relationship to the Patient:

- ☐ Parent of dependent minor child (copy of legal document is not necessary)
- ☐ Legal guardian or conservator ***
- ☐ Health Care Power of Attorney ***
- ☐ Executor or Administrator of Estate ***
- ☐ Other: _____ ***