AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. PATIENT INFORMATION.

Name: _____

SSN (last 4): _____

Date of Birth: _____

2. AUTHORIZATION FOR RELEASE. I hereby authorize:

The Offices of Michael A. Roman, Ph.D.
4242 Medical Drive, STE 7100
San Antonio, Texas 78229

to release, disclose, and deliver the medical information described below to:

_____
Provider and/or Agency Name

_____
Street Address

_____
City, State, Zip

3. SPECIFIC AUTHORIZATION. I specifically authorize the release of information relating to the above-named patient within the following categories protected by state or federal law:

- ☐ Inpatient or outpatient psychological, drug abuse, and/or alcohol abuse treatment records
- ☐ Admission and discharge summaries
- ☐ Psychological or neuropsychological evaluations, reports, or assessments including diagnoses, prognoses, recommendations, testing results, behavioral observations, questionnaires, and/or checklists, to the extent permissible by law
- ☐ Psychological treatment notes or summaries
- ☐ Social, family, educational, and vocational histories
- ☐ Evaluations and reports of other consultants that would normally be subject to redisclosure to covered entities based on my consent
- ☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- ☐ Billing records
- ☐ Insurance payment records
- ☐ Other: _____

_____

4. DATES OF CARE INCLUDED: This release is valid for dates of service from _____

to _____.

5. EXPIRY: This release will remain in effect for 180 days from the date of your signature OR until the expiration date or event listed below:

Date: _____ OR Event: _____

6. REDISCLOSURE. I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

7. REVOCATION. I understand that this authorization will automatically expire on the date specified above. I also understand that I have the right to revoke or cancel this authorization by sending a written notice to the Offices of Michael A. Roman, Ph.D. at the address listed above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

8. VOLUNTARY AUTHORIZATION. I understand that there may be a records fee charged to me by the office that is releasing the records and that I am financially responsible for this charge and any related charges that may apply such as authorized by law. I understand that I have a right to receive a copy of this authorization. I also understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from any of the professionals or facilities listed above.

9. RIGHT TO ACCESS. I understand that I may inspect the health information described in this authorization. Arrangements for scheduling an inspection of these documents can be made by calling the front office at (210) 342-1906. Except for certain exceptions (including raw test protocols and psychotherapy notes as defined by law), I understand that I may also be entitled to a copy of these documents. I further understand that if I wish to obtain copies of this information, I will be required to provide written notice of my desire to obtain these records, and I also agree to pay the fees for production of records currently in effect, as stated in the Practice Policies previously provided to me.

☐ I authorize the release of information as indicated above

_____ Date: _____
Signature

_____
Printed Name

_____
Relationship to Patient