Memory & Psychological Services, Inc.
Phone: 440-546-0048

Fax (preferred): 888-828-2326
8180 Brecksville Rd Ste 115, Brecksville, OH 44141

STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

SECTION I

First Name*	M.I.	**Last Name ***	**Date of Birth***	SSN *(last 4 digits)*

Address	City	State	Zip Code

SECTION II

☐ I hereby authorize Memory & Psychological Services, Inc. to **DISCLOSE & OBTAIN** my personal health information as described below:

☐ I hereby authorize Memory & Psychological Services, Inc. to **DISCLOSE ONLY** my personal health information as described below to:

☐ I hereby authorize Memory & Psychological Services, Inc. to **OBTAIN ONLY** my personal health information as described below from:

Person or Entity*

Contact Information (e.g. telephone number, fax number, address, etc.)

SECTION III

Reason for Disclosure* ☐ Continuity of Care ☐ Legal ☐ Fitness for Duty ☐ Other

Health information to be **DISCLOSED** by Memory & Psychological Services, Inc. *(if marked above)* *

☐ Summary of Treatment ☐ Psychological Testing Results

☐ Other

Specify time period, if desired: Release only information from *(mm/dd/yyyy)* to *(mm/dd/yyyy)* .

Health information to be **OBTAINED** by Memory & Psychological Services, Inc. *(if marked above)* *

☐ Summary of Treatment ☐ Imaging/Test Results ☐ Collateral Information ☐ Medical Records

☐ Other

Specify time period, if desired: Release only information from *(mm/dd/yyyy)* to *(mm/dd/yyyy)* .

Please fax (preferred) to 888-828-2326 or mail to Memory & Psychological Services, Inc., 8180 Brecksville Rd Ste 115, Brecksville, OH 44141.

SECTION IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by sumitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event:

• I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.

• I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

Signature of Individual*	**Date*** *(mm/dd/yyyy)*

Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(personal representative shall submit proof of authority to the disclosing entity)*

☐ Parent ☐ Legal Guardian ☐ Healthcare Power of Attorney ☐ Executor/Administator ☐ Other

For administrative use only:

Method of delivery *(e.g. paper, fax, electronic, etc.)*	Date released

rev 9-2022