Beljan Psychological Services
9835 E. Bell Rd., Ste. 140
Scottsdale, AZ 85260
www.beljanpsych.com

If you would like me to coordinate care with another care provider, complete this form to authorize release of your information:

AUTHORIZATION FOR RELEASE OF INFORMATION

Based on the federal HIPAA privacy rule, we must obtain an authorization from you in order to use or disclose protected health information (i.e., information regarding our client's health care or treatment that specifically identifies him/her) for purposes other than normal health care operations. An authorization may also be requested from a provider prior to the release of medical records. Please fill in any blank areas below and return the form to the address shown at the bottom of this page.

I. The Protected Health Information being requested for use or to be disclosed is as follows:

I HEREBY AUTHORIZE;

Treating Clinician:

- ☐ **Paul Beljan, PsyD, ABPdN, ABN**
- ☐ **Vanessa Berens, PhD**
- ☐ **Darci Weaver, Psy D**
- ☐ **Kate Haskew, CAGS, NCSP, ABSNP**
- ☐ **Other:**

Agency: **Beljan Psychological Services**
Address: **9835 E. Bell Rd., Ste. 140** **Phone: (602) 957-7600**
Scottsdale, AZ 85260 **Fax: (480) 289-5751**

TO EXCHANGE INFORMATION WITH/TO:

Name: _____ Agency: _____

Address: _____ Phone: _____

_____ Fax: _____

The following: **Copies of records to include**:

- ☐ Psychological/Neuropsychological Evaluations
- ☐ Medical Evaluations/Summaries
- ☐ Psychiatric Evaluations/Summaries
- ☐ Speech and Language Evaluations
- ☐ Occupational Therapy Evaluations
- ☐ Individual Education Plans (IEPs)/504 Plans
- ☐ Developmental History
- ☐ Current Medication List
- ☐ Progress Reports/Status Report
- ☐ Coordination of Care
- ☐ Consultant's Reports
- ☐ Other:

Regarding: _____ **Date of Birth:** _____

Specific reason that the Protected Health Information is needed: for developing and implementing an appropriate treatment plan, and/or to ensure continuity of care between current treatment providers.

II. Important Information About Your Rights

The following statements describe your rights in regard to this authorization:

- You may revoke this authorization at any time prior to its expiration date by providing written notice; however, the revocation will not have any effect on any actions that were taken before the revocation was received.
- You may access and copy the protected health information described in this authorization.
- This authorization is voluntary; you are not required to sign this form in order to receive health care benefits for enrollment, treatment or payment.

III. Signature of Patient

(This form must be signed by the patient; however, a parent/guardian must sign if the patient is a dependent child under the age of 18).

I hereby authorize the use or disclosure of my protected health information as described in this form.

_____ _____

Signature of Patient (or Parent/Legal Guardian) **Date**

_____ _____

Administration Signature **Date**

This authorization is valid for one year, unless otherwise rescinded by the patient. This authorization expires on: _____
Date