Richard L. Ruegg, Ph.D., H.S.P.P.
Psychologist

Greenwood Counseling Associates, Inc.
399 West Main Street ~ Greenwood, IN 46142
317.885.1150 fax 317.885.1070
gcaruegg@aol.com

RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Client Name ____ DOB _______________________

Address ____

I authorize ____ to release the following protected health information:

☐ Diagnosis ☐ Medication ☐ Progress & Treatment

☐ Results of Testing ☐ Social History ☐ Reason for termination

☐ Recommendation ☐ Psychiatric Evaluation ☐ Psychotherapy Notes

☐ Number of appointments ☐ Classroom/Medical/ Psychological Records

☐ Other ___________________________

This information may only be disclosed to____
(name of person or organization authorized to receive information)

for the following reason:

☐ To comply with court order ☐ For treatment of client

☐ To comply with doctor referral ☐ Collaboration with school

☐ Other ___________________________

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for the regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken.

THIS CONSENT WILL EXPIRE AT THE END OF 60 DAYS.

____ _______________________
Signature of Client Date signed

____
Signature of parent, guardian, or legal representative

____
Signature of Witness

The receiving agency understands that it CANNOT DUPLICATE any of the Confidential information received without Client's written consent.

Revised 4/2012