Yorlan
PSYCHOLOGICAL ASSOCIATES

3601 Concord Road
York, PA 17402
Tel: (717) 885-0503
Fax: (717) 650-1281
www.yorlanpsych.com

Release of Information

1. I am completing this form to allow the use and sharing of Protected Health Information about:
   Printed Name: _____ Date of Birth: _____

2. I authorize _____ to use, receive or disclose the following information:

   ☐ Treatment Summaries ☐ History ☐ Evaluation Reports ☐ Discharge Summaries
   ☐ Medical/Medication Treatments ☐ Progress Notes/Update ☐ Recommendations
   ☐ Any related information for psychological/behavioral health

3. Dates of care includes:
   ☐ All through ____/____/_____
   ☐ ____/____/_____ to ____/____/_____

4. To / From (Circle one or both): _____
   Address: _____
   Phone: _____ Fax: _____

5. The information will be used/disclosed for the following purposes:

   ☐ Continuity/Coordination of Care
   ☐ Responding to Family Concerns
   ☐ Referral

6. I understand this authorization is valid for 1 year from the date of signing or until revoked. I understand after the date or event; no more information can be released to the person or organization unless I sign a new authorization.
7. I understand I can cancel this authorization in writing. A letter will prevent any release of information after the date it is received, but cannot change the fact that information may have been released before that date.
8. I understand I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or affect my eligibility for benefits. If a refusal does affect my treatment or benefit, I will be notified immediately.
9. I understand that I may inspect and have a copy of the health information described in this authorization.
10. I understand if a person or entity receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

_____ _____
Signature of Client (or Personal Representative) Date

_____ _____
Printed Name of Client (or Personal Representative) Relationship to Client

_____
Description of Personal Representative's Authority

I, a health professional, have discussed the above issues with the client. My observations of his or her behavior give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Professional Printed Name of Professional & Date