QuaLife Psychology, LLC
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CONSENT FOR MUTUAL DISCLOSURE

I authorize the use, disclosure, or exchange of my Personal Health Information as described below:

Patient Name: _____ Date of Birth: _____

I hereby give my permission to QuaLife Psychology, LLC to use, disclose, or exchange my Personal Health Information with this person or organization:

_____

Name Telephone # Fax #

I am authorizing the use, disclosure, or exchange of the following Personal Health Information:

- ☐ Dates of Service
- ☐ Initial Evaluation & Diagnostic Impression
- ☐ Treatment Plan
- ☐ Treatment Progress
- ☐ Clinical Notes
- ☐ Other: _____
- ☐ Psychological Tests
- ☐ Medical / Labs
- ☐ Discharge Summary
- ☐ Verbal Exchanges
- ☐ Entire Record

This Personal Health Information will be used, disclosed, or exchanged for the following purpose(s):

- ☐ Diagnosis & Evaluation
- ☐ Formulation of Treatment Plan
- ☐ Other: _____
- ☐ Psychological Assessment
- ☐ Court-Ordered Evaluation

• I understand that if all items above or Entire Record are checked, the requesting person may receive the complete contents of my records, and that QuaLife Psychology, LLC, cannot under a full release take responsibility for the disclosure of this information. It is assumed that parties to whom information is released will be discrete in disclosing information.

• I understand this authorization is voluntary. I understand that if the person / entity authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

• I understand this authorization will be valid and in effect for 365 days from the date of signature, unless otherwise specified. I understand and agree that this Authorization will be valid and in effect until: _____

• I understand that I can revoke or cancel this authorization at any time by sending a letter to QuaLife Psychology, LLC. If I do this, it will prevent any disclosures after the date it is received.

• I affirm that I have had full opportunity to read and consider the contents of this Authorization, that everything in this form which was not clear to me has been explained, and that the contents are consistent with my direction.

• I acknowledge that I have received a copy of this completed form.

_____ _____

Patient Name (print) Patient Signature

_____

Date