JOSEPH S. BUSEY, PH.D.
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form when completed and signed by you, authorizes me to release Protected Health Information [PHI] from your clinical record to the person or persons you designate. It also authorized the below-listed people/businesses to release your PHI to me. This form was designed for HIPAA compliance under the aegis of the American Psychological Association and modified by Dr. Busey.

I authorize Joseph S. Busey, Ph.D., ABPP, and the people/businesses listed the paragraph below, to release to each other the following: (Provide specific and detailed description of the information that you want disclosed.)

_____
_____
_____

This information should only be released between Dr. Busey and the following people/businesses: (Provide name or function and address of person to whom the information is to be released)

_____
_____
_____
_____
_____

I am requesting Dr. Busey and the above-listed people/businesses to release this information for the following reasons, and subject to the following limitations: ("At the request of the individual" is all that is required from the patient if he/she does not desire to state a specific purpose.)

_____
_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure):

_____
_____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to Dr. Busey's office address, above. However, my revocation or modification will not be effective he receives it. Upon his receiving it, he will notify the people/businesses above.

I understand that Dr. Busey generally may not condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in Sections I through III of the Notice form provided by him, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, he may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule. Also, the recipients (people/ businesses) must take their own steps to be HIPAA compliant. Dr. Busey is not responsible for their non-compliance.

_____

Printed Name of Patient Signature of Patient Date

_____

DOB Social Security Number Address Phone

(If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.)