Nancy Marwick DeMuth, Ph.D., M.B.A.
Licensed Psychologist
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(717)763-8144

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Client Name: _____ **Date of Birth: ____/____/____**

MD, Group Name or Other: _____

Street Address, City, State, Zip: _____

Phone: _____ Fax: _____

MD, Group Name or Other: _____

Street Address, City, State, Zip: _____

Phone: _____ Fax: _____

MD, Group Name or Other: _____

Street Address, City, State, Zip: _____

Phone: _____ Fax: _____

I do hereby consent and authorize **Dr. Nancy DeMuth, Ph.D., MBA** to disclose and obtain the following information:

___ Evaluations (Psychological, Psychiatric, etc.)	___ Progress Notes	___ Medication List
___ Treatment Plan	___ Diagnosis(es)	___ Medical History
___ Treatment Summary	___ History (e.g. Substance Abuse, PTSD, etc.)	___ Lab Results (TSH)
___ Attendance in Treatment	___ Prognosis/Patient Data	___ Hospital Summaries

___ Other: _____

Purpose of Information: [ ] Coordination of Care [ ] Transfer of Care [ ] Education Planning

[ ] Securing Benefits [ ] Other: _____

You may revoke an authorization at any time in writing, except to the extent that the covered entity has taken action on reliance thereof or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest the claim under the policy or the policy itself.

This authorization was revoked by patient on _____at _____.

The covered entity may not condition treatment, payment, enrollment or eligibility for benefits under a health plan or whether the individual signs this authorization except (1) for prior to enrollment in the healthcare plan for determining risk rating or underwriting as long as it does not require disclosure of psychotherapy notes or (2) for purposes of disclosing protected healthcare information to a third party (for example, an evaluation to determine eligibility for life insurance). Failure to sign an authorization in the above situations could result in denial of enrollment in the healthcare plan. This information is being disclosed from protection health information whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Law 93-282, and/or Code of Federal Regulations, 42 (Drug and Alcohol treatment records).

This authorization shall expire six (6) months after discharge from treatment unless otherwise specified: _____

X_____ _____

Client Signature **Date**