# Psychological Associates of Yankton, LLC

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## Authorization for Exchange of Information

Patient Name _____ Birth Date _____

Street Address _____ City _____ State _____ Zip Code _____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

**I understand that I may revoke this authorization at any time by notifying Psychological Associates of Yankton, LLC. in writing, but if I do, it will not have any effect on any actions PAY took before it received the revocation.**

**I hereby authorize Psychological Associates of Yankton, LLC. to (check all that apply):**

☐ Exchange with ☐ Release to ☐ Obtain from the parties I have indicated below

**I hereby authorize Psychological Associates of Yankton, LLC. to exchange / release / obtain information:**

☐ verbally only ☐ in written form only ☐ both verbally and in writing

**Person/organization receiving/communicating the information:**

Name: _____

Address: _____

City _____ State _____ Zip _____

Phone Number: ( _____ ) _____ Extension _____

**Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained:**

☐ All ☐ Treatment Plan(s) ☐ Outpatient Progress Reports ☐ Attendance Only

☐ Other (describe): _____

**The purpose of this release is (check all that apply):**

☐ Continuity of Care ☐ Treatment Coordination ☐ Other (describe): _____

**I understand that this authorization will expire:**

☐ On _____ (MM/DD/YYYY) or one year from the date of the signature below.

Signature of Patient/Legal Guardian _____ Signature of Minor Patient _____ Date _____

Print Name of Patient's Representative _____ Relationship to the Patient _____

Witness _____ Date _____


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