Hamner Psychological Services

Main Office
917 W. Main Street
Harron Square, Suite 203
Bridgeport, WV 26330
(304) 842-7007

Tammy M. Hamner, M.A. — **Licensed Psychologist, WV#570**
Jeff S. Collins, M.A. — **Licensed Psychologist, WV#909**
Michelle L. Wetzel, M.A. — **Licensed Psychologist, WV#993**
Lauren Swann, LPC — **LPC, WV #2142**

Fairmont Office
301 Adams St.
Suite 800
Fairmont WV 26554
(304) 366-9001

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

(This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.)

Patient Name:_____ Age:_____ Birth Date:_____/_____/_____

Dates of Treatment: ___/___/___ To: ___/___/___ Social Security #_____

TO RELEASE INFORMATION:

I hereby authorize

Hamner Psychological Services

917 W. Main St., Suite 203

Bridgeport, WV 26330

To release information to:

_____

_____

_____

TO OBTAIN INFORMATION

I hereby authorize

_____

_____

_____

To release information to:

Hamner Psychological Services

917 W. Main St., Suite 203

Bridgeport, WV 26330

SPECIFIC INFORMATION TO BE RELEASED:

___NO LIMITATIONS OR

___Psychiatric Evaluation	___Laboratory Data	___History and Physical
___Psychoeducational Evaluation	___Psychosocial Evaluation	___Other_____
___Psychological Evaluation	___Discharge Summary	_____

___Verbal and Written communication regarding progress/aftercare recommendations "of the patient's psychiatric and/or mental health and/or addictions treatment".

Purpose for release of information:_____

Authorization is valid from ___/___/___ to ___/___/___ unless revoked by written or verbal request

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that this information may include information related to my diagnosis, prognosis, and/or treatment and I voluntarily consent to its release.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless 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 the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I certify that I have read and understand the preceding statements.

Patient Signature:_____Date:_____

Parent/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

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

VERBAL CONSENT:

I certify that the above named person verbally or by some physical sign indicated that he/she understands the nature of this release and freely consents to the release of his/her records.

Witness/Date_____Witness/Date_____