Feil & Oppenheimer Psychological Services

260 Waseca Ave.
Barrington, RI 02806
401-245-4040
Fax: 401-245-1240
feiloppenheimer@gmail.com

Authorization to Release Protected Health Information

I authorize

❑ Leslie A. Feil, Ph.D.	❑ John T. Jones, Ph.D.	❑ Matthew R. Picerno, Ph.D
❑ Peter M. Oppenheimer, Ph.D.	❑.Karen E. Fallon, Psy.D.	❑ Jessica L. Stewart, Psy.D
❑ Catherine Hoefliger, Psy.D.		.

and his/her/their administrative and clinical staff to ❑ request from and ❑ release to information ❑ my clinical record and/or ❑ the clinical record of ____________________________
(date of birth)____
to (name, address and telephone number of person to whom the information is to be released and/or received) ____
____

I authorize the staff members of Feil & Oppenheimer Psychological Services indicated above to release this information for the following reasons: ("at the request of the individual" is all that is required if you are our patient and you do not desire to state a specific purpose.)

____

This authorization shall remain in effect until (date) ________________________ or until (a reason)
____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we 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 my psychologist usually do not make psychological services contingent 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 based on this authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

______________________________ ________________

Signature of Patient/Guardian Date

Relationship to Patient: ____

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.

Feil & Oppenheimer Psychological Services complies with the laws and regulations of the United States of America, the State of Rhode Island and the Ethical Code of the American Psychological Association regarding the maintenance and communication of health care records.