Farrow Psychological Services, Inc.

9320 Carmel Mountain Road, Suite D
San Diego, California 92129

Telephone (858) 480-1484
cfarrow@charlesfarrowphd.com

Authorization for Use or Disclosure of Health Information

Explanation: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Dr. Farrow cannot condition services on whether or not you sign this authorization except under limited circumstances, such as for services related to research, eligibility or enrollment determinations, or services performed solely to creat information for an outside requestor (such as worker's compensation). In these circumstances, Dr. Farrow may refuse services unless you provide an authorization for the disclosure of your information. Please be aware that once your information leaves Dr. Farrow's office, Dr. Farrow will no longer be able to protect that information, and the recipients of our information may not be legally required to protect your information.

Authorization: I hereby authorize Charles E. Farrow, Ph.D. on behalf of Farrow Psychological Services, Inc., 15373 Innovation Drive, Suite 200, San Diego, CA 92128 (858) 480-1484 cfarrow@charlesfarrowphd.com______________

x to furnish to {and} x to obtain from
Name and address of facility or individual: ____
____

health records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of:

(Name of Client) ______________________________ Date of Birth: _____________

Dates of Service: ____

Location of Service: x Psychologist's office □ Inpatient □ Other ________________________

This authorization is limited to the following records and type of information:

□ Summary of Therapy □ History/Diagnostic Evaluation □ Neuropsychological Evaluation

□Progress Notes □ Other (please specify any limitations): ___________________________

Uses: The requestor may use the health records and type of information authorized only for the following purposes:

x Continuing Care □ Inspection of Record Only □ Legal Matter □ Insurance Claim □ Personal Copy

□ Second Opinion □ Other (Please Specify): ____

Initials ______ pg. 1 of 2

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Duration: I understand this authorization may be revoked in writing at any time, according to the instructions in Dr. Farrow's HIPAA Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six months for the date of this authorization.

Restrictions: I understand that Dr. Farrow may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Dr. Farrow from any/all liability that may arise from the release of this information to the party named above.

Additional Copy: I further understand that I have a right to receive a copy of this authorization upon my request. (Civil Code S.56.11)

Signatures:

______________________	____________	______________________
Signature	Date	Witness
______________________	____________	______________________
Relationship to the Client	Area Code & Phone Number	Date/By

Initials ______ pg. 2 of 2