The Nicholls Group

Exchange Of Record Form

PATIENT INFORMATION

Patient Full Name

Date of Birth

Patient Address

City

State

Zip Code

Home Phone/Cell Phone

Email

Release Records/Request for Records:

This form when completed and signed by me, authorizes Dr. _____ and/or his/her staff to

○ release ○ receive ○ exchange protected health information (PHI) to/from the following individuals:

Business/Facility/Name:

Phone Number:

Fax Number:

Address:

Business/Facility/Name:

Phone Number:

Fax Number:

Address:

The following information may be shared:

☐ Assessment Results ☐ Evaluation Report ☐ Diagnostic Information

☐ Summary of Therapy Sessions ☐ Summary of Clinical Findings ☐ Any and all information necess

I am requesting that this information be shared for the following reasons:

☐ Treatment Planning ☐ Billing ☐ Updates ☐ Other:

This authorization shall remain in effect until _____ or no longer than 6 months from the date of signature.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The Nicholls Group office address, as indicated above. However, my revocation will not be effective to the extent of any action already taken in reliance on the authorization. I understand that my clinician 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 re-disclosure by the recipient of my information and therefore, it is no longer protected by the HIPAA Privacy Rule.

My name printed below serves as my legal signature.

Signature

Date

Relationship to Client