Linda K. Hinkle, Ph.D., HSPP
Hope Psychological Services, P.C.
13295 Illinois St., Ste. 321
Carmel, IN 46032
Phone: (317)815-5680 Website: www.drlindahinkle.com

Authorization Form

This form, when completed and signed by you, authorizes a health care provider to release and/or receive protected health information from your clinical/medical records.

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ PHONE: _____
CITY: _____ STATE: _____ ZIP: _____

I hereby request Linda K. Hinkle, Ph.D., HSPP/Hope Psychological Services, P.C. to:
[ ] RELEASE TO: [ ] OBTAIN FROM:

Person/Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax (if known): _____

Information Requested:
[ ] Diagnosis and Evaluation
[ ] Psychological Testing/Assessment
[ ] Alcohol/Drug Evaluation
[ ] Progress Notes
[ ] Lab Results/Drug Screen
[ ] School Records
[ ] Phone Calls
[ ] Psychosocial History
[ ] Treatment Plan
[ ] History/Physical Exam
[ ] Discharge Summary
[ ] Discharge Instructions
[ ] Entire Patient Record
[ ] Letters
[ ] Other: _____

Purpose of Release:
[ ] To Aid in Treatment
[ ] Other: _____
("At the request of the individual" is all that is required if you are a patient and do not desire to state a specific purpose.)

I understand that this request may be revoked by me by sending such revocation, in writing, to the office address of Linda K. Hinkle, Ph.D., HSPP/Hope Psychological Services, P.C. I also understand that such revocation will not be effective to the extent that action has been taken 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 health care services may not be conditioned upon my signing an authorization unless the 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 the information and no longer protected by the HIPAA Privacy Rule.

I understand that this request will be valid for one hundred eighty (180) days from the date written below. At that time the request will be void and no futher information will be furnished pursuant to it.

A copy of this authorization shall be as valid as the original.

_____ _____
(Patient/Parent/Guardian Signature) (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: _____