James P. McHugh, Ph.D.
Authorization to Release information

(This form, when completed and signed by you, authorizes Dr. McHugh and/or his staff to release protected information from your clinical record to the person or persons you designate. This information may include family and treatment history, diagnosis, treatment, your response to treatment, session notes, insurance and payment information and any other information in your chart.)

I hereby authorize Dr. James P. McHugh, Ph.D. and/or his administrative staff to release the following information as specified below (check one):

- ❑ Any and all information regarding my psychiatric/psychological history, condition and treatment.
- ❑ Only the information specified below:

_____

Format (Check One): ❑ Complete Copy of All My Records ❑ Summary Letter

The **Protected Health Information** specified above should only be released to:

_____
Name

_____
Address

_____

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

_____
"at my request" is all that is required

This authorization shall remain in effect until: _____

I understand that my mental health professional generally may not condition health care services upon my signing an authorization unless the health care services are provided to me for the purpose of creating health care information for a third party. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

You have the right to revoke this authorization, in writing, at any time be sending written notification to Dr. McHugh at PO Box 14814, Lenexa, KS 66285-4814. However, your revocation will not be effective to the extent that action has already been taken in reliance on this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ _____/_____/_____ _____/_____
Print Your Name Date of Birth (MM/DD/YYYY Mon & Yr of Last Contact

_____ _____
Address (Street, City, State, Zip) Phone

_____ _____
Signature of Patient Signature of Parent or Guardian

_____
Relationship to Patient