Anxiety & Agoraphobia Treatment Center
112 Bala Avenue, Bala Cynwyd, PA 19004
610.667.6490; Fax 610.667.1744
www.aatcphila.com

Authorization for Disclosure of Protected Health Information

Name__________________________________ Date of Birth ________________
(please print)
I hereby authorize the Anxiety and Agoraphobia Treatment Center to obtain from and/or release to:

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copies of medical records or other information pertaining to my treatment of _____________(dates) for the purpose of ____ Developing an individualized treatment plan
____ Coordination of care with other healthcare professionals
____ Peer supervision & consultation with AATC Staff Therapists
____ Other ____

Information can be released via mail, email, telephone or fax but is limited to:
_____ Dates, diagnosis and treatment summary
_____ No restrictions apply
_____ Other ____

I understand that the confidentiality of these records is protected by federal and state law and that they cannot be released except as indicated above without my written consent unless special circumstances as authorized by laws governing release of information are applicable.

I understand that this authorization will remain in effect until (fill in expiration date or an event that relates to the individual or the purpose of this disclosure) _________________ ______________ and that I may withdraw my consent at any time (except for action already taken) by written request to the Anxiety and Agoraphobia Treatment Center.

I understand that my therapist generally 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

________________________________ ____________________________
Signature Date

________________________________ ____________________________
Signature of parent or guardian if person is under age 14 or declared legally incompetent Date

_______________________________ ____________________________
Witness Date