



INTEGRATED PSYCHOLOGICAL SERVICES
EMPLOYEE ASSISTANCE PROGRAMS INC.

AUTHORIZATION TO OBTAIN/RELEASE PROTECTED INFORMATION

PATIENT'S NAME _____ DATE OF BIRTH _____

I AUTHORIZE MATRIX TO SECURE/RELEASE THE FOLLOWING INFORMATION RELEVANT TO MY CASE:

- CASE SUMMARIES
PSYCHOLOGICAL TEST DATA
TREATMENT PLAN
DATES OF SERVICE ONLY
OTHER (SPECIFY)
DISCHARGE SUMMARY
CLIENT PROGRESS VIA TELEPHONE
MEDICAL HISTORY

RELEASE TO RECEIVE FROM EXCHANGE WITH

NAME _____

ADDRESS _____

PHONE _____

I AM REQUESTING MATRIX TO RELEASE THIS INFORMATION FOR THE FOLLOWING REASONS:

- AT MY REQUEST
OTHER _____

THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL _____

I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME, BY SENDING SUCH WRITTEN NOTIFICATION TO MATRIX AT 2 EASTON OVAL, SUITE 450, COLUMBUS, OH 43219. HOWEVER, MY REVOCATION WILL NOT BE EFFECTIVE TO THE EXTENT THAT MATRIX HAS TAKEN ACTION IN RELIANCE ON THIS 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. A COPY OR FACSIMILE TRANSMISSION OF THE ORIGINAL OF THIS AUTHORIZATION SHALL BE TREATED WITH THE SAME FORCE AND EFFECT AS THE ORIGINAL HEREOF.

I UNDERSTAND THAT MATRIX GENERALLY MAY NOT CONDITION PSYCHOLOGICAL SERVICES UPON MY SIGNING AN AUTHORIZATION UNLESS 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 THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT OF THE INFORMATION AND NO LONGER PROTECTED BY THE HIPAA PRIVACY RULE.

SIGNATURE OF PATIENT DATE _____

SIGNATURE OF PARENT OR GUARDIAN DATE _____

PHONE: 614-475-9500/ 800-886-1171
FAX: 614-475-9821

2 EASTON OVAL, SUITE 450
COLUMBUS, OH 43219