Andrea Barbour, MA
NPI #1023438892

AUTHORIZATION FOR RELEASE OF INFORMATION
A copy shall be valid as original

Name: _____ Date of Birth: ___/____/____

Address: _____ SS#: _____/_____/_____

City: _____ State, Zip Code _____

I hereby authorize **Andrea Barbour, MA**
❑ to release ❑ to obtain

Records ❑ To/from: _____
Name

_____
Address

_____
Phone Number Fax Number

_____
Email Address

Please check information to be released:

❑Initial Assessment and Treatment Plan ❑ Progress Notes
❑ Psychological Evaluation ❑ Psychiatric Evaluation
❑ Diagnosis ❑ Discharge Summary ❑Other:
❑ Verbal ❑ Written

The purpose for use or disclosure of information:

❑ Continuity of Care ❑ Coordination of Services
❑ Other: please provide a specific description of the purpose/use for disclosure:

_____

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and cannot be released or re-released without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time, except to the extent that release has already occurred.

This consent is valid for 90 days from the date signed by the patient or authorized party below, unless revoked by me prior to that date, upon the completion or satisfaction of the event or conditions specified; whichever comes first. A copy of this authorization shall be valid as the original.

Patient/Legal guardian: _____ Date: _____

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Record Retrieval $25.00
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