AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, ________________________________ hereby authorize ___Dr. Tanisha M. Ranger__________________________
(Address&Phone): ___Insight to Action LLC ____
___1481 W Warm Springs Rd, Suite 132____
___Henderson, NV 89014____

To provide/obtain:

☐ Assessment	☐ Dates of Treatment	☐ Psychological Testing Report
☐ Diagnosis	☐ Discharge Plans	☐ Presenting Symptoms
☐ Progress to Date	☐ Psychiatric Evaluation	☐ Treatment Plans & Recommendations
☐ Entire File	☐ Prognosis	☐ Other __________________

To designee or representative of (Recipient): ___________________________________ _________________________

(Address &Phone): ____
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I authorize the disclosure of the health information described above for the continuation and follow-through of appropriate treatment. The specific uses and limitation on the uses of my health information by Recipient are as follows:
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I understand I have the right to:

1. Revoke this authorization, in writing, at any time, except to the extent that action has already been taken in reliance upon it
2. Inspect a copy of Patient Health Information being used or disclosed, under Federal Law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

Duration: this authorization shall be effective immediately.

I have carefully read and understand the forgoing. I voluntarily consent to the release of the above-specified **Protected Health Information (PHI)**, which may include psychiatric illness and alcohol and/or drug abuse and dependence, and AIDS/HIV status to those persons or agencies listed above. I further release my attending therapist, and her associates from any liability arising from the release of this information or records to such designated persons or entities. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.

Restrictions: Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

I understand that Provider cannot condition treatment upon me signing this authorization.

Provider is authorized to disclose the protected health information specifically listed above until: ______________
(authorization expiration date).

____ _______________
Signature of Patient or Patient's Authorized Representative *Date*

**If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:*

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Insight to Action LLC
Tanisha M. Ranger, PsyD, CSAT
Augusta Park Complex | 1481 W. Warm Springs Rd, Suite 132 | Henderson, NV 89014
dr.ranger@insighttoaction.net | 484.483.3093 | www.insighttoaction.net