Revised Release of Information Form
For Health Insurance, Disability Insurance, Life Insurance Companies

Name :_____

SSN: _____

DOB: _____

I do not believe that the Authorization for Release of Information provided by you complies with HIPAA privacy rules. As such, I am not willing to sign it.

I am willing to sign an authorization for release as described below:

Authorization for Release of Information to _____is limited as follows:

1. **I am <u>not willing</u> to release any psychotherapy notes from any provider of psychotherapy.**
2. **I am <u>not willing to</u> release medical information without restriction.**
3. **You <u>have permission</u> to request and review treatment summaries from treating physicians. This information may include and is limited to: dates of service, diagnosis, treatment, progress, and prognosis. The doctors you may contact for such information are:**
4. **I am <u>not willing</u> to release copies of my federal income taxes. I feel that this is an excessive invasion of my privacy.**
5. **You <u>may contact</u> Social Security Administration to confirm any income on my behalf. However, you <u>may not</u> request copies of my federal income tax returns from them. I have provided them with this information and they can confirm the status of any and all work activity in this regard.**
6. **You <u>may also contact</u> Social Security Administration to confirm the status of my disability if/when I am disabled.**
7. **You <u>may not share</u> any information you obtain in this regard with any other agency that is not DIRECTLY RESPONSIBLE for making decisions in the administration of claims, benefits, re-insurance, and coverage.**
8. **This is the extent of sharing of information I am willing to provide. My privacy is important.**

I understand that if I refuse to sign the original authorization provided by you, you may decline to process my claim. If this is the case, I understand that I have a right to receive an explanation of that decision, and how any limitations I presented prevented processing my claim.

This authorization will remain in effect, canceling all prior ones, for one year following the date of my signature.

_____ _____

Patient Name/Signature Date

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