Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, ____(psychologist's name)_____ and/or his or her administrative and clinical staff (cross out if not applicable) to release (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.) _____

_____

This information should only be released to (name and address of person to whom the information is to be released)

_____

_____

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the 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.

I understand that my psychologist 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 of Patient Date

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.