PSYCHOLOGICAL STRATEGIES, LLP

Authorization to Release Information

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 therapist, _____ to release the following (Please initial each item if consent is given)

_____ Dates of service, symptoms, diagnosis
_____ Treatment Progress
_____ Psychotherapy Notes
_____ Other (describe in specific detail) _____
_____ Treatment Plan
_____ Test Results

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

_____
_____

I am requesting my therapist 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 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 therapist 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

_____ _____
Signature of Witness Date

If 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.

Patient Name: _____ **Patient ID _____**