# PSYCHOLOGICAL STRATEGIES, LLP

## Authorization to Obtain Information

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

I authorize my therapist, _____ to obtain the following information: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible):

_____
_____
_____

This information should be obtained from (name and address of person from whom the information is to be obtained)

_____
_____
_____

I am requesting my therapist to obtain 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.

_____ _____
Signature of Patient (or legal guardian) Date

_____ _____
Signature of Witness 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.

**Patient Name: _____** **Patient ID: _____**