Authorization Form

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

I authorize my psychologist, Marcia Hemley, Ph.D., to release to and obtain information related to my psychotherapy or medical treatment.

This information should only be exchanged with _____

_____.

I am requesting my psychologist to release this information for the following reasons:

_____To facilitate my psychotherapy treatment.

Describe other reason: _____

_____

This authorization shall remain in effect until _____.

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 my information and no longer protected by the HIPPA Privacy Rule.

_____ _____

Signature of Patient Date