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Authorization to Obtain or Release Information

None of the information or records obtained under this authorization may be re-released to another party.

Client Name: _____ DOB: _____

I, _____, hereby authorize Stephanie Smith, Psy.D. to obtain or disclose (indicate) the following information:

____Confirmation of participation in therapy
____Psychological testing results
____Summary of evaluation findings
____Academic Records
____Billing/Payment Information
____Treatment progress
____Treatment summary
____On-going consultation
____Other_____

This information is to be released for purpose of:

psychological evaluation_____
treatment planning _____
to coordinate services_____
other _____

This authorization shall remain in effect until (give date or event):

(until revoked)_____
(6 months) _____
(1 year) _____
other_____

This information should only be released to or obtained from:

Name: _____ Phone: _____

Address: _____

Fax: _____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Smith's office address. However, my revocation will not be effective to the extent that Dr. Smith has 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 Dr. Smith 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 HIPAA Privacy Rule.

_____ _____

Client Signature Date

_____ _____

Therapist/Witness Signature Date