Connie Umphred, R.N., Ph.D.

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Two Way Authorization Form

This form when completed and signed by you, authorizes **Connie Umphred, R.N., Ph.D.** and the person you designate, to release to each other protected information from your clinical record.

I, _____ authorize and request mutual exchange of protected information from my clinical record between **Connie Umphred, R.N., Ph.D.** and (provide name, address, and phone number of the authorized person):

_____

_____

_____

_____

and / or their administrative and clinical staff. (Provide description of the information that you want disclosed. Your description should be as specific and as detailed as possible.)

_____

_____

I am requesting the release of this information for the following reasons: ("At the request of the individual" is all that is required from the patient if he/ she does not desire to state a specific purpose.)

_____

_____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

This authorization shall remain in effect until (fill in expiration date earlier than 180 days) or until I notify you willing of termination of the release. DATE: _____

I understand that my psychiatrist generally may not condition psychiatric services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that once information leaves this office, it is the responsibility of the recipient to protect the in formation according to the HIPAA privacy rule.

SIGNATURE OF PATIENT: _____ DATE: _____

_____

(If a personal representative of the patient signs this authorization, a description of such representative's authority to act for the patient must be provided.)

SIGNATURE OF WITNESS: _____ DATE:_____

REVISED 04/14/2008-jb