Authorization for Release of Information Form

Client's Name: _____ Date of Birth: _____
(first name last name) (mm/dd/yy)

Printed name of client's representative: _____
Relationship to client: _____

I hereby authorize Joanna T. Koulianos, Ph.D. and Associates, Inc. to use or disclose individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

INFORMATION AUTHORIZED: (check or specify) □ All records □ Other: _____

DATES AUTHORIZED: (check or specify) □ Within last 12 months □ Other: _____

PURPOSE OF REQUEST: (check or specify) □ Treatment □ Ongoing Communication
□ Authorized Representative's Request □ Other: _____

INFORMATION CAN BE: □ Exchanged □ Released Only

PERSONS / ORGANIZATIONS: (complete all fields)

NAME	ADDRESS	PHONE / FAX #	RELATIONSHIP

READ THE FOLLOWING STATEMETS AND INITIAL HERE: _____

- I understand that this authorization will expire on this date: _____ (mm/dd/yy) or within one (1) year of the date of the request.
- I understand that I may revoke this authorization at any time by notifying the providing organization and completing a Revocation of Authorization Form. I understand that revocation will not apply to information that has already been released in response to this authorization.
- I understand that authorizing the disclosure of this private health information is voluntary and I may refuse to sign this authorization.
- I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.

_____

Signature of client or client's representative Date

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CLINICAL PSYCHOLOGY
Joanna T. Koulianos, Ph.D. and Associates, Inc.