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Authorization Form

This form when completed and signed by you, authorizes me to release and receive protected information from your clinical record to the person you designate. Use this form if you would like me to communicate with your family physician, psychiatrist, or another doctor. **(OPTIONAL)**

I authorize my psychologist, Dr. Bonnie Cleaveland and/or her administrative and clinical staff to release and receive (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible)

This information should only be exchanged with (name and address of person to whom the information is to be released)

I am requesting my psychologist to release and/or receive 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 until (fill in 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 psychologist generally may not condition psychological services upon my signing an authorization to release records 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 your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient Date