AUTHORIZATION TO RELEASE INFORMATION

This form, when completed and signed by you, authorizes the Clinical Psychology Center ("CPC") to release protected health information from your clinical record to the person or organization you designate.

I, _____, authorize the CPC to release:
(Print first and last names)

_____
_____
_____
(Please describe the information you wish to have disclosed as specifically and in as much detail as possible)

This information should only be released to:

_____
_____
_____
(name, address, and phone/fax of person/organization to which information should be released)

I am requesting that the CPC release this information for the following reasons:

_____
_____
(If you are a client of the CPC, it is sufficient to state, "To support continuity of treatment" or "To support needed services")

This authorization is to remain in effect until:

_____
(*Indicate expiration date or event which terminates authorization)*

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification of the same to the CPC's office address. However, I understand that my revocation will not be effective to the extent that the CPC 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 the CPC generally may not condition the provision of services on my signing an authorization, unless such 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 the information. In such a case, the information may not be protected by the HIPAA privacy rule.

_____ _____
Client signature Date

_____ _____
Witness Date

If this Authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.