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AUTHORIZATION FOR RELEASE OR EXCHANGE OF PROTECTED HEALTH INFORAMTION (PHI)

This form, when completed and signed by you, authorizes me to release/receive/exchange protected health information from your clinical record to/from/with the person(s) you designate

I authorize my provider, Gail L. Lisson, Psy.D., to release and/or exchange protected health information from my medical record to the following:

Name:_____

Address:_____

Tel: _____Fax:_____

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 information used for disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA patient Privacy Rule.

Full Name:_____SSN:_____

Signature:_____Date:_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided

Nature of Relationship: _____