AUTHORIZATION FOR RELEASE OF INFORMATION

Troy E. Johnson, PsyD, LLC
11978 Fishers Crossing Drive Fishers, IN 46038

Patient Name:	**Date of Birth:**
Street Address:	
City / State:	**Zip:**

I authorize Troy E. Johnson, PsyD, HSPP to release information to / obtain information from:

Name:	
Address:	
City / State:	**Zip:**
Phone:	**Fax:**

Information to be disclosed:

Dates of Service: □ **Yes** □ **No**	**Medical Record:** □ **Yes** □ **No**
Clinical Impressions: □ **Yes** □ **No**	**Educational Recommendations:** □ **Yes** □ **No**
Discharge Summary: □ **Yes** □ **No**	**Other:** □ **Yes** □ **No**

I am requesting my psychologist to release this information for the following reasons:

At the request of the individual: □ **Yes** □ **No**	**Coordination of care:** □ **Yes** □ **No**
Other:	

This authorization shall remain in effect until (date)_____ or until the termination of treatment but no longer than one year from the date of execution.

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 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.

This form, when signed by you, authorizes Troy E. Johnson, PsyD, HSPP to release protected information from your clinical record to the person you designate.

_____ _____
Signature of Authorized Party / Guardian Date

_____ _____
Witness Date