**Audrey Cleary, Ph.D.**

**5915 Ponce De Leon Blvd. Suite 19**

**Coral Gables, FL 33146**

**(305) 767-1108**

AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to exchange protected information from your clinical record with the person or organization that you designate.

I authorize Audrey Cleary, Ph.D., FL Psychologist No. PY8599 to exchange my clinical case information with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am requesting this information be exchanged with Dr. Cleary for the following reasons: (“at the request of the individual” is all that is required if you are my patient and you do not wish to state a specific purpose.)

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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.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(This authorization will expire 6 months from the date of the signature below unless you have specified otherwise.)

You have the right to revoke this authorization at any time by providing written notification. However, your revocation will not be effective for action already taken based on the authorization or if this authorization was obtained for a legally required reason.

I understand that Dr. Cleary 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 if I am Dr. Cleary’s patient, the information used or disclosed to this authorization will continue to be protected by the HIPAA Privacy Rules.

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Signature of Patient 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.