RELEASE OF INFORMATION Authorization Form

This form when completed and signed by you, authorizes me to release or receive protected information from your clinical record to or by the person you designate.

I authorize my psychologist, Katherine Prakken, PhD, to plan my treatment by disclosing or receiving the following information:

Clinical information relevant to coordination of care

This information should only be released to or received from: (name and email of person to whom the information is to be released/received)

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I am requesting my psychologist to release/receive information for the following reasons: ("at my request" is all that is required if you are my patient and you do not desire to state a specific purpose.)

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This authorization shall remain in effect until: (End of treatment or other)

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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 am aware of my right to confidential communications under psychologist-patient privilege. 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

Signature of Patient ____

Date _________________