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NYS License 009145

## Authorization For Disclosure of Protected Health Information

This form when completed and signed by you, authorizes me to release protected information from your/your child's clinical record to the person you designate. It also gives your consent for the individual or institution listed below to release any and all of your/your child's educational, psychological/psychiatric and other records directly to me.

Name of Patient: ____________________________________ DOB:____________________

I authorize my psychologist, Dr. Barbara Edell Fisher to release the information listed below:

______Verbal Summary of my treatment to date
______All relevant psychological and written evaluation data
______Only this specific information

This information should only be released to: ________________________________________
________________________________________
________________________________________

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This authorization shall remain in effect for one year from the above date unless revoked in writing prior to that date. You have the right to revoke this authorization, in writing, at any time by sending such written notification to the above 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.

__________________________________________ ______________________
Signature of Patient of Parent of Minor Patient Date

__________________________ ________________________
Printed Name Relationship to Patient