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RELEASE OF PROTECTED HEALTH INFORMATION –AUTHORIZATION FORM

Name of Client ______________________________ Birthdate: ______________________

I authorize Felicia Mueller, Psy.D. to release and exchange the following protected health information:

____

(Provide specific description for the information that you want disclosed.)

This information should only be released to and exchanged with:

Name: ____

Contact Information: ____

I request Felicia Mueller, Psy.D. disclose this information for the following reasons (check one):

☐ To facilitate treatment and/or evaluation of myself or my family member

☐ Other ____

(Provide a reason for the disclosure)

This authorization shall remain in effect until (check one):

☐ Treatment has been terminated ☐ Date: ______

☐ Event: ____

(Fill in an event that relates to the individual or use of the disclosure)

After this expiration my therapist can no longer use or disclose my protected health information without first obtaining a new authorization form.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification. However, I also understand that this revocation will not be effective to the extent that my therapist has taken action in reliance on the authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

_______________________________ _______________________ __________

Signature of Client or Personal Representative Printed Name Date

____

Personal Representative's authority (e.g., "Parent" or "Guardian")

____ __________________

Witness Date