

Stephanie L. Ezust, Ph.D.

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 *Authorization Form* 

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

I authorize my psychologist, **Stephanie L. Ezust, Ph.D.**, to release: *(Please provide a description of the information you'd like me to disclose. Your description should be as specific and detailed as possible although it's fine to check, "All relevant information" if you don't wish to limit the information released to the individual below.)*

All relevant information

Other: _____

This information should only be released to the following individual and/or their staff:

Name: _____

Address: _____

Phone Number: _____

I am requesting that my psychologist, Stephanie L. Ezust, Ph.D., release this information for the following reasons: *(You may just check "At the request of the individual" if you are my client and you don't want to state a specific purpose.)*

At the request of the individual

Other: _____

This authorization shall remain in effect until (fill in expiration date) _____ or until *(fill in an event that relates to the individual to whom this information is being released and/or the purpose of the use or disclosure)*.

You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address or by speaking to me about it during a session. 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, Stephanie L. Ezust, Ph.D., 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.

Print Name of Client

Signature of Client

Date

(If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the patient must be provided.)