AUTHORIZATION FOR RELEASE OR EXCHANGE OF PROTECTED HEALTH INFORMATION (PHI)

This form, when completed and signed by you, authorizes me to release/receive/exchange protected health information from your clinical record to/from/with the person(s) you designate.

I authorize Samuel D. Smithyman, Ph.D., a licensed clinical psychologist and/or his or her administrative and/or clinical staff to release and/or exchange the following information: *(check all that apply):*

___ Copy of file or chart - *OR* -
___ Diagnosis/Diagnostic Impressions
___ Testing/Assessment Results
___ Prognosis/Impressions/Recommendations
___ Treatment Plan
___ Psychotherapy Notes
___ Other (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

_____
_____
_____

This information should be released to, received from and/or exchanged with:

Name: _____

Address: _____
_____
_____
_____

Tel: _____ Fax: _____

E-mail: _____

I request that Dr. Smithyman release/receive/exchange this information for the following reason(s): ("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)

_____
_____
_____
_____

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).

_____

You have the right to revoke this authorization, in writing, at any time by written notification to me at my office address. However, your revocation will not apply if I have relied on the authorization to obtain insurance reimbursement or coverage and/or the insurance carrier has a legal right to contest your claim.

I understand that Dr. Smithyman generally may not condition psychological services upon my signing this authorization unless the psychological services are provided to me for the purpose of creating health information for a third party, such as a legally entitled insurance carrier.

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

Full name: _____

SSN: _____

Signature: _____

Date: _____

Witnessed: _____

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.

Nature of Relationship:

_____