AUTHORIZATION FORM

Patient Name: _____.

Date of Birth: _____

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 Debra J Myers, MD, PsyD, to release the following: All information related to psychotherapy evaluation and treatment.

This information should only be released to:

I am requestin Debra J Myers, MD, PsyD to release this information for the following reasons, and subject to the following limitations:

This authorization shall remain in effect until

I understand that I have the right to revoke/modify this authorization, in writing, at any time by sending written notification of that revocation/modification to **Dr. Myers'** office address. However, my revocation or modification will not be effective until **Dr. Myers** receives it. I understand that **Dr. Myers** generally may not condition psychotherapy services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in Sections I through III of the Notice form provided by **Dr. Myers**, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, **Dr. Myers** may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) the psychotherapy 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 this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

_____

_____

Signature of Patient **Date**

_____

Print Patient Name