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Authorization Form to Obtain/Release of Information

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, Matthew Silverstein, Ph.D., to obtain/release the following: (Provide description of the information that you want disclosed.)

___Pertinent treatment information

___A copy of treatment records

Other (Your description should be as specific and detailed as possible.):
_____
_____

This information should only be obtained from/released to the following: (Provide name (or function), institutional affiliation and address of person from/to whom the information is to be obtained/released.)
_____
_____

I am requesting my psychologist to obtain/release this information for the following reasons, and subject to the following limitations:
_____
_____

This Authorization shall remain in effect until one year after the date of my signature on this form or until _____(fill in an event that relates to the individual or the purpose of the use or disclosure). I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that the psychologist has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ Signature of Patient or Legal Guardian   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.