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Authorization Form for Release of Protected and Confidential Information

By signing this form, I authorize Sharon L. Doss, Ph.D. to use and disclose information described below.

Patient Name _____

Date of Birth _____

The information that may be released, subject to this authorization is as follows:

_____

_____

_____

Release this information to the following person(s) or entity:

Name _____

Address: _____

City: _____ State: _____ Zip: _____

The reasons or purposes for this release of information are as follows:

_____

_____

_____

Unless otherwise revoked, this authorization shall be in force and effective until the following event or date _____

If I fail to specify an expiration date or event, this authorization will expire in one year.

I understand that I have the right to revoke this authorization at any time by sending a **written notification** request to Sharon L. Doss, Ph.D. I understand that a revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Finally, I understand that authorizing the disclosure of confidential information is completely VOLUNTARY. I can simply refuse to sign this authorization. I need not sign this form to obtain services in this office. I understand that the disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of this confidential information, I can contact Sharon L. Doss, Ph.D.

_____ _____

Signature of Client or Legal Representative Date

_____

Relationship to Client