Bob Dick, Ph.D, C.G.P., A.C. Clinical Psychologist
Permission to Share Information

Name____DOB_______________________________________

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

I authorize the exchange of information between ___________________________and the following:

1. Primary Care or Referring Physician

Name______________________________________Phone________________________________

Address____

City___________________State_____________Zip______________Email___________________

2. Other (please specify name, organization, address):

Name______________________________________Phone________________________________

Address____

City___________________State_____________Zip______________Email___________________

3. Other (please specify name, organization, address):

Name______________________________________Phone________________________________

Address____

City___________________State_____________Zip______________Email___________________

Extent of information to be released includes: ____

____

This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with those individuals or companies for the specific purposes of evaluation and treatment. If shall not be considered a blanket waiver of all privileged and confidential information.

I am requesting this information exchange for the purpose of____.

This authorization will remain in effect for two years unless you designate a different time period below. You may revoke this authorization at any time by giving us written notice. Expiration if different from above _____________________

This authorization is fully understood and is voluntarily made on my part.

______________________________________ or ____

Patient's Signature Parent   Legally appointed representative's signature

______________________________________   ____

Date of Signature   Relationship if not parent

Witnessed by: _______________________________ Date: ____

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 HIPPA Privacy Rule.

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