AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:

Date of Birth:

Address:

Phone:

Parent or Legal Guardian:

This form, when completed and signed by you, authorizes Dr. Ross/Child and Family Psychology of Carrboro to share protected information from your or your child's clinical record by:

_____Releasing of information to_____

_____Exchanging information with_____

_____Requesting information from_____

This information will include: Testing Treatment Plan Therapy Notes All of the Above Other (Specify):

I am requesting the exchange of information for the following reason:

Name of person or agency
Address
Phone, Fax number

This authorization shall remain in effect in effect for: 180 days, or ending ___/ ___/ _____, or till the end of the treatment

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological 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 the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient (if over 18)

Date:

Signature of Parent or Legal Guardian