Authorization form for Exchange of Information

This form, when completed and signed by you, authorizes me to exchange and share protected information from your clinical record to the person/entity you designate.

I authorize consultation regarding my therapy between Maureen McNeal, LICSW, LMFT

and _____ to exchange information and consult regarding the following protected health information:

_____ All information from my Clinical Record with the following exceptions: _____

_____

_____

_____ All psychotherapy notes with the following exceptions: _____

_____

_____

I am requesting my psychotherapist to release this information for the following reasons: ("at my request" is sufficient)

_____

_____

This authorization shall remain in effect until _____ (date) or until _____

_____ (a specific event related to purpose of release).

I am aware that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Maureen McNeal's office address. However, my revocation will not be effective to the extent that Ms McNeal has 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 psychotherapist 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 my information and no longer protected by the HIPAA Privacy Rule.

Signature of Client _____ Date _____