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Authorization ("Authorization") for the Disclosure of Protected Health Information ("PHI") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA")

Parent Name(s): _____

Children's Names: _____

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

This information should only be released to:

_____	_____
Name	Phone number
_____	_____
Name	Phone number
_____	_____
Name	Phone number
_____	_____
Name	Phone number
_____	_____
Name	Phone number

1. Description of PHI to be disclosed:

   The release of privileged information and records, including alcohol and drug rehabilitation, and the exchange of any information and records for the purpose of evaluation, treatment, progress reporting, and/or referral. Information exchanged may include, but is not limited to, history, assessments, references to or results of HIV antibody (AIDS) testing, test results, examinations, notes psychotherapy progress notes/reports and any other information.

   I authorize the release of this information and records in writing and/or verbally.

   I represent and guarantee that I have full legal and binding power and authority to sign and execute this Authorization on behalf of the minor children listed above.

2. Time frame: Birth to Present

3. The PHI will be disclosed for the following purposes: For review, analysis, evaluation, and use in providing psychological services and/or your divorce matter.

4. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by federal and state privacy regulations.

5. 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.

6. I understand that I may revoke this Authorization, in writing, at any time by sending or faxing a written notice to Dr. Ellis at the contact information listed above. The written revocation must state my intent to revoke this Authorization. However, I understand that any actions already taken in reliance on this Authorization cannot be reversed, and any revocation will not affect those actions.

7. Any facsimile, copy, or photocopy of this Authorization shall be as valid as the original.

_____ _____

Signature Date

_____ _____

Signature Date