

# FRY HEALTH

## Authorization Form to Obtain/Release of Information

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

I authorize my psychologist, Rachel B. Fry, Ph.D., to obtain/release the following:

(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

Pertinent treatment information   Results of neuropsychological evaluation  
Results of psychological assessment      A copy of treatment records  
Other (Your description should be as specific and detailed as possible.):

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This information should only be obtained from/released to the following: (Provide name (or function), institutional affiliation and address of person from/to whom the information is to be obtained/released.)

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I am requesting my psychologist to obtain/release this information for the following reasons, and subject to the following limitations:

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This Authorization shall remain in effect until \_\_\_\_\_ (expiration date) or until \_\_\_\_\_ (an event that relates to the individual or the purpose of the use or disclosure). However, I understand that this Authorization does not permit disclosure of my future health care given more than 90 days from the date of this Authorization (unless this is for disclosures to insurance companies). If this Authorization does not contain an expiration date, the Authorization expires 90 days from the date of my signature.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that the psychologist has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance 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 this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

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Signature of Patient or Legal Guardian

Date \_\_\_\_\_

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.