Directions, a Center for Life Strategies, LLC
Tamsen Thorpe, Ph.D., Director
Licensed Psychologist # 3826
20 Community Place – 4th floor
Morristown, NJ 07960
O: (973) 425 - 8868
Fax: (973) 539-3687

Authorization Form

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, Tamsen Thorpe, Ph.D. and/or her contractors_____ to release (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible. The information may include for example; diagnoses, symptoms, stressors, treatment plan.)

_____

This information should only be released to:
(name, address and phone of person to whom the information is to be released)

_____
_____

I am requesting to release this information for the following reasons: (If you do not desire to state a specific purpose, please circle the following: "at the request of the individual")

_____
_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

_____
_____

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 therapist 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient/Guardian: Date:

_____

Print Name: Date of Birth:

_____

If applicable, relationship to patient: _____