Sharon Ryan Montgomery, Psy.D.
Licensed Psychologist - NJ License #1931

Associate
Tamsen Thorpe, Ph.D.
Licensed Psychologist-NJ License #3826
20 Community Place, 4th Floor, Morristown, NJ 07960
Tel: 973 425-8868/Fax: 973 539-3687

Authorization/Release Form

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

I (**Name of litigant/patient):**_____
authorize my psychologist/evaluator, Tamsen Thorpe, Ph.D. and/or administrative and clinical staff to release/obtain information:

To/From Whom: _____
This information should only be released to/obtained from (name and address and/or phone number of person to whom the information is to be released to/obtained from)

Purpose:_____
I am requesting Tamsen Thorpe, Ph.D., to release/obtain this information for the following reasons: *(*"Custody Evaluation", "Parenting Coordination", or "at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until the end of treatment and/or evaluation and/or litigation.

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 Tamsen Thorpe 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.

_____ **Date** _____
Signature of Patient/Litigant

Print Name :_____
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.