

Directions CLS, LLC
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Authorization Form

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

I authorize my psychologist, Tamsen Thorpe, Ph.D. to obtain/release:

(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible. The information may include some or all of, for example: diagnoses, symptoms, stressors, treatment plan.)

Designated Person Name: _____

Phone/email: _____

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/evaluator 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: _____