

Licensed Psychologist

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**Authorization For Release of Information**

Regarding the protected health information of: \_\_\_\_\_

This form when completed and signed by me, authorizes the professional on this letterhead to release verbal information or information from my clinical record to the person or organization designated below.

I authorize you and/or you administrative and clinical staff to release the following information:

Verbal:  Yes  No -  Any Information  Only: \_\_\_\_\_

Written:  Yes  No -  All Records  Only: \_\_\_\_\_

I understand that this information may contain references to mental health, substance abuse, and/or HIV.

This information should only be released to: (name and contact information of person or organization):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am requesting the release of this information for the following reasons (“at my request” is all that is required if you do not desire to state a specific purpose):

\_\_\_\_\_

This authorization shall remain in effect until (check one):

Revoked by me in writing

Until (fill in an expiration date or 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 delivering such written notification to me. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage.

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 the authorization may be subject to redisclosure by the recipient of your information and no longer protected by privacy laws.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed 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 (e.g., parent, legal guardian, etc.).