Changes Psychological Services, PLLC
Authorization Form

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

I _____ (Patient name) authorize my psychologist _____ to release the following information (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.):

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

I am requesting that my psychologist release this information for the following reasons ("At the request of the individual" is all that is required if you are a patient and you do not desire to state a specific purpose):

_____

_____

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) _____. NOTE: Except as provided in the next paragraph, the authorization shall be in effect no longer than 60 days from the date you sign this form.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Changes Psychological Services, PLLC at 1629 K St. NW, Suite 300, Washington, DC 20006. However, your revocation will not be effective to the extent that your psychologist has 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. Additionally, you may not revoke where an authorization is executed in connection with your obtaining a life or noncancellable or guaranteed renewable health insurance policy, in which case the authorization shall be

specific as to its expiration date, which shall not exceed 2 years from the date of the policy; or where an authorization is executed in connection with your obtaining any other form of health insurance, in which case the authorization shall be specific as to its expiration date, which shall not exceed 1 year from the date of the policy.

I understand that I have the right to inspect the disclosed mental health information at any time.

I understand that Changes Psychological Services, PLLC 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 my information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient/Representative 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 below:

_____

_____