

Lucas S. Rockwood, Psy.D.

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Authorization to Release Information

Patient Name _____ Date of Birth _____

I hereby give Lucas S. Rockwood, Psy.D., permission to obtain information from, release information to, and/or discuss my case and my protected information with the company, agency, or individuals listed below: _____

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 of 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 already taken action in reliance on the authorization.

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 re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Patient Name (Print)

Signature of Patient

Date

Parent/Guardian (Print)

Signature of Parent/Guardian

Date