



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:	Date of Birth:
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This form when completed and signed by you, authorizes East End Psychological Associates, LLC to release protected information from your clinical record to the person you designate.

I _____ authorize East End Psychological Associates, LLC to correspond and release/obtain relevant information to/from:

(Name of health care provider, agency, etc.)

(Address)

(Phone & Fax)

For the purpose(s) of: _____

In authorizing the release of confidential information, I hereby waive all restrictions and privileges imposed by law and release East End Psychological Associates, LLC and its staff from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.

I understand that this authorization may be revoked at any time, except to the extent that East End Psychological Associates, LLC has already taken action in release on it. My revocation must be in writing in a letter to East End Psychological Associates, LLC at the address listed on this authorization form.

I certify that I have read and received a copy of this authorization. This authorization supersedes any and all previous authorizations.

Patient's signature/Authorized Individual

Date

Witness

Date