Regina D. Morrow Ed.S., LMFT, LMHC, NCC
104 West 6th Avenue Windermere, FL 34786
(407) 876-2078 office (407) 876-7378 fax Reg@cfl.rr.com

Authorization Form: Regina to Other

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

Client name _____ Date _____

D.O.B. _____

Home Phone _____ Work or cell phone_____

I authorize:

_____
Name of person or organization

_____
Address

_____
Address

_____ _____
Phone Fax

to release _____

_____

This information should only be released to :

Regina D. Morrow Ed.S., LMFT, LMHC, NCC
104 West 6th Avenue Windermere, Fl 34786
(407)876-2078 office (407) 876-7378 fax

I am requesting my therapist to release this information for the following reasons:

_____
This authorization shall remain in effect until (expiration date) or until (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 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 Date

_____ _____
Signature of Parent or Guardian 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.