PATHS Psychological and Therapeutic and Healing Services, PLLC

Licensed Psychologist
Genie Burns, Psy.D.

Address

P:(999) 999-9999
F: (999) 999-9999

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Patient Name: _____ Patient Date of Birth: _____

I hereby authorize _____ to disclose to _____ the following information: [ ] Testing Results [ ] Thank You for Referral letter

[ ] Phone Consultation [ ] Other _____

for the purpose of _____ .

I understand that this Authorization is voluntary. I understand that I may revoke this Authorization at any time by notifying PALTHS, PLLC/Dr. Genie Burns in writing, but that doing so will not cancel any actions already taken in reliance on this Authorization. I understand that the duration of this consent will be no longer than would be necessary and reasonable to carry out the purpose for which it is given. Unless you wish to cancel this consent at an earlier time, it will automatically stop upon the date and/or event indicated:

Date/Event/Condition: _____ .

_____ _____
Signature of patient Date

_____ _____
Signature of parent/guardian/authorized person Date

_____ _____
Witness Signature Date

Note to party receiving information: This information has been disclosed to you from records whose confidentiality is protected by federal law which prohibits you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. (This form meets the requirements of Federal Regulation 42CFR, Part 2.)