

## AUTHORIZATION FORM

I authorize my psychologist, Dr. Kinta Parker, to release

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This information should only be released to

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I am requesting that Dr. Parker release this information for the following reasons (if you are my patient and do not desire to state a specific purpose, simply write "at the request of the individual"):

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This authorization shall remain in effect until (a particular date) or until (a specific event, such as formal termination of therapy):

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I have the right to revoke this authorization, in writing, at any time by sending such written verification to Dr. Parker's office. However, this revocation will not be effective to the extent that Dr. Parker has already 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 Dr. Parker generally may not condition psychological services up on 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

\_\_\_\_\_  
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.