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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

*This form, when completed and signed, indicates legal authorization and consent to release protected health information from your clinical record to or from the person you designate.*

I, ______________________________________________ authorize my psychologist, Dr. Nicole
*Printed name*
Alford, to [***CHECK ONE]*** release _____ receive _____ the following information from my clinical record to/from: [***YOUR DESCRIPTION SHOULD BE AS SPECIFIC AS POSSIBLE]:***

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

This information should only be released *(check one)* to _____ or from ____ the following: **(PLEASE provide the name/institutional affiliation or institution, address of the person to whom the information is to be released to:**

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

I am requesting my psychologist to receive this information for the following reasons and subject to the following limitations:

_______________________________________________________________________

_______________________________________________________________________

This Authorization shall remain in effect until (date) ___________________________, or until (event pertaining to you the client, or the purpose of the disclosure) ___________________________. If no date is specified, it will be valid for a period of 90 days from the date of this form. I understand that I have the right to revoke this authorization at any time, by providing such intent in writing, to the office of Dr. Alford.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_______________________________________________

Signature of Patient Date

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