Carol R. Hirshfield, Ph.D.

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AUTHORIZATION FORM TO CONSULT WITH OTHER PROFESSIONALS

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

I, _____authorize my psychologist,

Name of Adult (s)

Dr. Carol Hirshfield may discuss the following information:
(Provide description of the information that you want disclosed, be as specific and detailed as possible.)

_____

_____

This information should only be released to and from: _____

Name, Title, Company or Agency

_____

Address Phone Fax No.

I am requesting my psychologist to release this information for the following reasons, and subject to the following limitations: ("At the request of the individual" is all that is required from the patient if he/she does not desire to state a specific purpose.)_____

This remains in effect until_____ or end of treatment. (Circle one)
I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my psychologist's office address. However, my revocation or modification will not be effective until my psychologist receives it.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) 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 this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Signature of Patient or Parent/ Guardian Date