Richard D. Recor, Ph.D.

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Authorization To Exchange Patient Health Information

This form when completed and signed by you, authorizes me to exchange patient health information from your clinical medical records with the person/entity you designate.

I _____authorize my psychologist, Richard D. Recor, Ph.D. and/or his administrative and clinical staff to exchange the following: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

_____

This information should only be released between: (Provide name and address of person to whom the information is to be released)

_____

I am requesting release of this information for the following reasons:
_____ At my request.
_____ For the following specific reason: _____

This Authorization shall remain in effect until _____ or until this referenced event _____

However, I understand that this Authorization does not permit disclosure of my future health care given more than 12 months from the date of this Authorization (unless this is for disclosures to insurance companies); and shall be effective not more than 30 months from the date of this Authorization. If this Authorization does not contain an expiration date, the Authorization expires 12 months from the date of my signature.

- I understand that I have the right to revoke this authorization at any time, unless my psychologist has taken substantial action in reliance on the authorization.
- I understand that my psychologist 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 this consent includes disclosure of ALCOHOL AND DRUG ABUSE records which are protected by virtue of the provision of Federal Regulation 42 C.F.R. Part 2.

I make this consent upon the promise that all disclosures of my alcohol and drug abuse records made pursuant to this authorization shall be accompanied by the following notice:

> NOTE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of the information is *NOT* sufficient for this purpose.

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, Parent, or Legal Guardian Date

_____ _____
Signature of Witness Date