Julie A. Morrison, Psy.D.
5401 Twin Knolls Road, Suite 7
Columbia, MD 21045
PH 410-952-9574 FAX 888-972-9520
jm@drjuliemorrison.com

AUTHORIZATION FOR THE RELEASE OF INFORMATION

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

I authorize Julie Morrison, Psy.D. to release (provide as detailed a description as is possible regarding the information that you want disclosed) _____

_____

_____

This information should only be released to (name and address of the person to whom you want the information released) _____

_____

I am requesting that Dr. Morrison release this information for the following purpose ("at the request of the individual" is all that is required if you are the client and do not desire to state a specific purpose) _____

_____

I understand that Dr. Morrison cannot re-disclose information she received from another health care provider, if that health care provider requested that the information not be re-disclosed.

This authorization shall remain in effect until (fill in expiration date, which may not exceed one year) or until (fill in an event that relates to the individual or the purpose of the use or disclosure, which may not to exceed one year) _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. Your revocation will not be effective to the extent that I have 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. Morrison 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 information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Client or Legal Representative Date

Description of Authority to Act if Legal Representative: _____