Maurice Smith, Ph.D.
Licensed Psychologist

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form when completed and signed by you, authorizes Maurice Smith, Ph.D., LP, to exchange, release and/or request protected health information from your clinical records to the person you designate.

I, _____, DOB: ____/____/_____ authorize Maurice Smith, Ph.D., LP, to **REQUEST/RELEASE/EXCHANGE**:

☒	Educational Issues	☒	Psychiatric/Psychological Evaluation
☒	Social History Reports	☒	Medication History
☒	Physical Examinations	☒	Discharge Summary
☒	Psychological Test Interpretation	☒	Treatment for Drug &/or Alcohol Abuse
☒	Treatment Plan(s)	☒	Billing Information
☐	Other: _____	☐	Other: _____

This information should only be requested/released/exchanged with: _____
_____
_____

The information is being released for the following reasons "*AT THE REQUEST OF THE INDIVIDUAL*."

This authorization will remain in effect for **ONE YEAR** of date signed or until _____/_____/_____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, 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 Maurice Smith, Ph.D., LP, generally may not condition mental health services upon my signing an authorization unless mental health 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.

_____ _____ ____/____/____
Patient/Personal Representative Signature *Relationship to the Patient* *Date*

(If authorization is signed by a personal representative of the patient, a descriptor of such representative's authority to act for the client must be provided, e.g., "parent," "guardian," etc.)

_____ ____/____/____
Date

A COPY OF THIS AUTHORIZATION FORM SHALL BE AS VALID AS THE ORIGINAL