Michelle L Hobby Ph.D.
Clinical Psychologist License #PS018424

Authorization to Release and Exchange Confidential Information

Name of Patient:_____

Date of Birth _____ Phone Number _____

I hereby authorize the **release and exchange of information** between my psychologist, Michelle L Hobby, Ph.D. (855.414-2523), and the following individual, agency, or institution:

Name:_____

Address:_____

Phone:_____Fax:_____

E-Mail:_____

This authority extends to the furnishing of copies of all or any desired portion of the records pertaining to the above-named client. This exchange is for the purpose of_____
and expires _____ months from the date signed unless otherwise specified. You have a right to a copy of this authorization.

The parties named above are hereby released from all legal liability that may arise from this exchange or release of information. I understand that I may revoke this consent at any time by informing all of the above parties in writing. I also acknowledge that I have read and understand the other provisions relating to this authorization on the reverse side of this page. A photocopy or electronic copy is as valid as the original.

Signature:_____Date_____

PLEASE READ CAREFULLY THE ADDITIONAL INFORMATION PROVIDED ON THE REVERSE SIDE OF THIS PAGE BEFORE SIGNING THIS DOCUMENT.

- I understand that I can revoke or cancel this authorization at any time by sending a letter to Michelle L Hobby, Ph.D. who is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Hobby, nor will it affect my eligibility for benefits.

- I understand that I may inspect and have a copy the health information described in this authorization. _____Does not apply.

- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations.

- I understand that Dr. Hobby will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me, and I understand and accept it. _____Does not apply.

- I affirm that everything in this form that was not clear to me has been explained, and I believe I now understand all of it.

Statement of the Therapist

This document was discussed with the client and questions regarding its contents were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Date and Initials of Therapist_____