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MD License #03863 ***VA License #0810-002414***

Authorization Form

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

I authorize Victoria Balenger, PhD, to release the following type of information:
_____
_____

This information should only be released to: _____

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

This authorization shall remain in effect until _____ (expiration date or event that relates to the purpose of the disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such notification to my office address. However, any revocation will not be effective to the extent that I have already taken action in reliance on the authorization, or if this authorization was obtained as a condition of procuring insurance coverage and in surer has a legal right to contest a claim.

I understand that Dr. Balenger generally may not condition any psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of providing 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 my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date