

THERAPY SERVICES with Dennis Dyck, Ph.D

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Authorization for Release of Information

Client Name: _____ Date of Birth: _____

This form, when completed and signed by you,

- authorizes me to release protected information from your clinical record to the person you designated and
 authorizes the person you designated to release information to me.

Name/Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

This authorization for disclosure of protected information applies to the following types of information:

- Clinical Information Clinical Record Other (please specify): _____

This authorization pertains or relates to information regarding myself and/or the following minor child/children of whom I am the parent or legal guardian:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I understand that my records may contain protected information regarding diagnosis and/or treatment for HIV (AIDS virus) or other sexually transmitted diseases, drug/alcohol diagnosis and/or treatment, and/or Mental Health diagnosis and/or treatment. I give consent to release information regarding all of the following: (please initial next to each area)

_____ HIV/AIDS

_____ Drugs/Alcohol

_____ Mental Health

I am requesting the release of information for the following reason, and subjects to the following limitations:

- Continuity of Care Other (please specify): _____

Limitations: _____

This authorization shall remain in effect until: (Fill in an expiration date or an event that relates to the purpose of the disclosure.) Termination of Services Other (please specify): _____

If this authorization does not contain an expiration date or event, it expires 90 days from the date of signature.

I understand I have the right to revoke this authorization, in writing, at any time, by sending such written notice to Dr. Dennis Dyck. However, my revocation will not be effective to the extent that action has been taken in reliance on my authorization or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition services upon my signing an authorization unless the services are provided for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclose by the recipient of my information and no longer protected by HIPAA Privacy Rule.

Signature of Client: _____ Date: _____

Signature of Parent/Legal Guardian/DPOA: _____ Date: _____

Provider Signature: _____ Date: _____

Note: A photocopy or facsimile of the above signatures shall be considered in lieu of original. **If there is a fee for this service, please obtain prior approval from Dr. Dennis Dyck.**