

Authorization Form

This form authorizes EXCHANGE of protected information from the clinical record of:

Name: _____

DOB: _____

Between:

Stefanie Griffin, PhD
Northeast Evaluation Specialists
1 Washington Street, Suite 4144
Dover, NH 03820
Phone: 603-740-6371
Fax: 603-742-1414

And: (Provider Name) _____

(Provider Address) _____

(Provider Phone/Fax) _____

I authorize EXCHANGE OF THE FOLLOWING INFORMATION:

<input type="checkbox"/> Evaluations	<input type="checkbox"/> Discharge Summaries
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Aftercare Forms
<input type="checkbox"/> Patient Service Plans	<input type="checkbox"/> Raw Data

OR Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible:

This authorization shall remain in effect until ____/____/____ or until (fill in an event that relates to the individual or the purpose of the use or disclosure):

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Stefanie Griffin, PhD. However, your revocation will not be effective to the extent that Stefanie Griffin, PhD has 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 Stefanie Griffin, PhD generally may not condition services upon my signing an authorization unless the 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.

Signature of Patient or Patient's Legal Guardian

Date