Authorization Form

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

Name:_____

DOB:_____

Between: Tina Trudel, 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:

- ☐ Evaluations
- ☐ Progress Notes
- ☐ Patient Service Plans
- ☐ Discharge Summaries
- ☐ Aftercare Forms
- ☐ 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 Tina Trudel, PhD. However, your revocation will not be effective to the extent that Tina Trudel, 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 Tina Trudel, 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