Authorization Form

This form authorizes Tina Trudel PhD to release of protected information from the clinical record of:

Name_____DOB_____

To_____

For the following purpose

This authorization shall remain in effect until _____/_____/_____ or until (fill in 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 re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____

Signature of Patient or Patient's Legal Guardian Date