Paula Elitov, Ph.D.

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Phone/fax: 301-738-7990

AUTHORIZATION FORM

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

I authorize my psychologist, Paula Elitov, Ph.D. to release:
(Provide description of the information you want disclosed. Your description should be as specific as possible):

_____

_____

This information should only be released to (name and address of person to whom the information is to be released)

_____

_____

_____

I am requesting Paula Elitov, Ph..D. to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific reason).

_____

I understand that Paula Elitov, Ph.D. cannot redisclose information she received from another health care provider if that health care provider requested that the information not be redisclosed.

This authorization shall remain in effect until (fill in expiration date – may not exceed one year) or until (fill in an event that relates to the individual or the purpose of the use or disclosure – not to exceed one year).

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have 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 Paula Elitov, Ph.D. generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that the 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 parent, if a minor) Child's Name (Please print) Date

If authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.