

Paula Elitov, Ph.D.

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AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to contact another individual, to conduct a school observation, or participate in a school meeting.

I authorize my psychologist, Paula Elitov, Ph.D

_____ to contact the following individual _____ to conduct a school observation _____ to participate in a school meeting

Please indicate below the person you are giving permission for me to contact (may be another professional or individual, the name of the school and teacher or other school professional)

Name: _____

School: _____

Address/Phone _____

I am requesting my psychologist to make this contact or schedule this observation or meeting 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 my psychologist cannot disclose information she received from another health care provider if that health care provider requested that the information not be disclosed.

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 my psychologist 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)

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.