HIPAA Authorization for Release of Health Information

Susan M. Knell, Ph.D., LLC

Name _____ Date of Birth _____

I hereby authorize the use and disclosure of my individually identifiable health information as described below:

Persons/organizations authorized to provide information:

□ Susan M. Knell, Ph.D., LLC

□ Other:

Person/Organization: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

Persons/organizations authorized to receive information:

□ Susan M. Knell, Ph.D., LLC

□ Other:

Person/Organization: _____

Address: _____

_____

Phone: _____ Fax: _____

E-mail: _____

The following information can be disclosed:

□Assessment

□Treatment summary

□Other: _____

● This information is being disclosed for the purpose of treatment planning and coordination of care.

● I understand that this authorization is completely voluntary and may be revoked at any time, unless action has already been taken, by notifying the disclosing entity in writing. Please see the Notice of Privacy Practices for Protected Health information (PHI) form for information about your rights.

● I understand that the information disclosed may be re-disclosed by the recipient.

● I am not required to sign this form, and the covered entity may not condition treatment, payment or eligibility on based on the signing of this form.

●This authorization expires:

□ at the end of treatment

□ one year from today's date

□ on __/__/__

I hereby authorize that this information be disclosed as noted above.

Name _____ Relationship to patient _____

Signature _____ Date _____

Witness _____ Date _____