TRACY SAFF DOW Psy.D.
Doctor of Clinical Psychology

RELEASE OF INFORMATION AUTHORIZATION FORM

In most cases, we feel it is to your advantage that we work with your doctor(s), pastor or others who may have a role in your care. If you are here for a child-related problem, it is often helpful for us to have contact with his or her school. To communicate with these people about you or your child, we need permission.

Please sign the following Release of Information, if you choose, which allows us to discuss you and/or your child with each designated person and/or mail letter/reports to them.

This form when complete and signed by you, authorizes Dr. Tracy S. Dow to release protected information from your clinical record to the person you designate.

I, _____ authorize Dr. Tracy S. Dow and/or his/her administrative staff (cross out if not applicable) _____ to release:

- ❑ PHI (e.g., diagnosis, treatment goals)
- ❑ PHI (billing records)
- ❑ Clinical Summary of Progress
- ❑ Other_____

This information should only be released to and similarly received from:

Name:_____

Address:_____City:_____ Zip: _____

Cell # (_____) _____ Email: _____

I am requesting my clinician to release this information for the following reasons:

_____

❑ at the request of the individual is all that is required if you (or your child) are a client and you do not desire to state a specific purpose).

This authorization shall remain in effect until _____ (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure) _____ _____. If left blank, this authorization shall expire one year after date signed below.

You have the right to revoke this authorization, at any time by sending written notification to my office address. However, your revocation will not be effective to the extent that Dr. Dow has taken action in reliance on the authorization.

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I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and may no longer be protected by the HIPAA Privacy Rule. In signing this form, I realize that I write my right to confidentiality between Dr. Dow and the above noted second party.

Signature of Client _____

OR

Parent-Guarantor _____

Date _____

Witness _____

Notice to receiving agency or person: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to criminal investigate or prosecute any alcohol or drug abuse clients.