Betty-Shannon Prevatt, MA, LPA
Clinical Psychologist

Authorization Form

This form, when completed and signed by you, authorizes Betty-Shannon Prevatt, MA, LPA to release protected information from your clinical record to the person you designate below.

I, ____(DOB ____/____/____), authorize Betty-Shannon Prevatt, MA, LPA and/or her administrative staff to release the following materials (provide a specific and detailed description of the information you want disclosed)

____

____

This information should only be released to

Name: ____

Address: ____

Phone/Fax: ____

By initialing this section I authorize the above named person to communicate with Betty-Shannon Prevatt, MA, LPA regarding me. _______________

I am requesting Betty-Shannon Prevatt, MA, LPA to release this information for the following reasons: ("At the request of the individual" is all that is required if you are a client and you do not desire to state a specific purpose.)

____

This authorization shall remain in effect until ___________________ or until ___________________________________
(Fill in an event that relates to the individual or the purpose of the use or disclosure).

I have the right to revoke this authorization, in writing, at any time by sending such written notification to Betty-Shannon Prevatt, MA, LPA. I understand that Betty-Shannon Prevatt, MA, LPA generally may not condition psychological services upon my signing an authorization. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

____ ___________________
Signature of Client Date

____ ___________________
Signature of Witness Date

If a personal representative of the client signs the authorization, a description of such representative's authority to act for the client must be provided.