



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.