NEW BEGINNINGS PSYCHOLOGICAL RESOURCES, P.C.
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AURORA, CO 80044-0763
303-777-5536

Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, Noëlle Fellman, Psy.D./Eugene Van Dusseldorp, Ph.D. (circle one) and/or her/his administrative and clinical staff to release/exchange the following information:

_____ PHI information only
_____ Admission/discharge summaries
_____ Verbal/written progress
_____ HIV records
_____ Other: Please specify_____

_____ Psychotherapy notes
_____ Psychological evaluation/testing
_____ Educational information
_____ Alcohol/substance abuse records

This information should only be released to or exchanged with:

_____
_____

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

_____

This authorization shall remain in effect until: _____

I acknowledge that I have made this request voluntarily.

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 hereby release my psychologist from any liability which may result from furnishing the information requested.

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 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.

A copy of this authorization is to be considered as valid as the original, and is to be acted on upon receipt of this form.

_____ _____
Signature of Client Date

_____ _____
Witness Date

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