Richland Psychology, PLLC
9037 E. D Ave
Richland, Mi 49083
(269) 629-2207

Authorization of Release of Confidential Information

This form when completed and signed by you, authorizes the release of Protected health Information from your clinical record to the designated person or entity.

Name: _____ DOB: _____

I authorize Richland Psychology, PLLC to release the following information:

_____
(Provide description of the information that you want disclosed. Be as specific as possible)

This information should only be released to:

_____

_____
(Name and contact information of person or entity to whom information is to be released.)

I am requested this release of information for the following reason ("at the request of individual" is all that is required if you do not desire to state a specific purpose.) _____

This authorization shall remain in effect until _____ (expiration date) or until (this

event) _____

You have he right to revoke this authorization in writing at any time by sending such written notification to this office. However, your revocation will not be effective to the extent that action in reliance on the authorization has already occurred 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 understand that my provider 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 re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule. If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____