Ψ SUSAN C. REEDER, Ph.D.
Licensed Psychologist
PY0004516

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Inverness, FL

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P.O. Box 563
Inverness FL 34451

Authorization Form

I authorize my psychologist, Susan C. Reeder, Ph.D. and/or her administrative and clinical staff to release or request the following protected information: (Please provide a description of the information you want disclosed. Your description should be as specific and detailed as possible).

_____

_____

I hereby authorize and request the release of the following information:

____Psychological ____Psychiatric ____Psychosocial ____Medical ____Education ____ Other ____

This information should only be released between Susan C. Reeder, Ph.D. and (name and address of person to whom the information is to be released).

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_____

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

_____

I understand that communicating this information may include telephonic or electronic transmittal in addition to standard mail service or in person dialogue.

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).

_____

This authorization may be revoked, in writing, at any time by sending such written notification to the above PO Box. However, the revocation will not be effective to the extent that action has been taken 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 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.

In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of information. I understand that the confidentiality of information used or disclosed pursuant to this authorization and in accordance with HIPAA Privacy Rules can not be guaranteed by Dr. Reeder's practice once said information leaves this office.

_____

Print Name Phone Number Address

_____

_____

Signature of Patient or Personal Representative Date

_____

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