Authorization for Release of Records

This form authorizes Lindsey Geiger to release and exchange protected health information from your clinical record to people specifically designated by you.
Patient Name_____
DOB_____

I authorize Lindsey Geiger to release and/or exchange information about my psychological history, conditions, and status. This may include information regarding my drug and alcohol history, mental health treatment and conditions, and/or HIV/AIDS or other medical diagnoses.

This information may be released to and exchanged with the following doctors, hospitals and/or others:
___ Referring doctor:_____ Doctor's phone number: _____ Doctor's fax number: _____

___PCP:_____ PCP's phone number: _____ PCP's fax number:_____

___Other:_____ Phone number: _____ Fax number:_____

___Other:_____ Phone number: _____ Fax number: _____

I am authorizing release and exchange of this information at my request and of my own free will. This authorization shall remain in effect: *until I withdraw my permission to release and exchange this information in writing*, or other:_____

I have the right to revoke this authorization, in writing, at any time by sending written notification to Lindsey Geiger. However, my revocation will not be effective to the extent that Ms. Geiger has already 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 understand that a psychotherapist 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 of my information and no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient and Date

_____ _____
Signature of Patient's Authorized Representative and Date
A description of such representative's authority legally to act for the patient must be provided if the authorization is signed by a personal representative of the patient.