Troy Psychological Services PLLC

Sarah Gates, Psy.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

Patient Address: _____

Responsibly Party Name (parent): _____

Relationship to Patient:_____

I hereby authorize Sarah Gates, Psy.D.

to OBTAIN FROM [ ] _____

and/or RELEASE TO [ ] _____

the following information from the record of the above named patient:

_____

The purpose of this transfer of information is: _____

If you checked the OBTAIN FROM box, your signature below authorizes Sarah Gates, Psy.D. to obtain information either verbally or in writing from the party you designate. That information will become part of your record.

If you checked the RELEASE TO box, your signature below authorizes Sarah Gates, Psy.D. to communicate, either verbally or in writing, with the party designated. Please be advised that once she releases information she cannot assure that the recipient will protect such information in accordance the HIPAA Privacy Rule.

You have the right to revoke this authorization by sending a letter to Sarah Gates, Psy.D. It will be effective the day she receive it. It will have no bearing on any information released prior to the receipt of your letter of revocation.

This authorization will be effective for one year from the date signed.

Signature/Responsible Party: _____ Date: _____