Barbara Forloney, APRN, CNS, CNP

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Authorization to Release Protected Health Information

I authorize Barbara Forloney, and her administrative staff to □ request from and □ release to information from □ my clinical record and/or □ the clinical record of _____ (DOB: _____). If requested, specify information to be disclosed:

This information is to be released to OR received by: (name, address, and telephone number to whom the information is to be released and/or received):

I am requesting my therapist 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 (date) _____ or until (a reason):

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 understand that my therapist may not condition clinical services upon my signing an authorization unless the clinical 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.

_____ _____

Signature of Patient (or Parent/ Legal Guardian) Date

_____

Relationship to Patient