AUTHORIZATION FOR THE RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

I hereby authorize Laura Lokker, Psy.D. to exchange protected health information below with these parties:

_____

Requested information:

I authorize the disclosure of the following types of clinical records created during the period from first contact with Dr. Lokker through the date of signature below, unless another time period is specified:

___ Attendance (appointments scheduled and met; dates of service)
___ Safety concerns (level of danger to self or others)
___ Alcohol and other drug use
___ Billing records
___ Other: _____
___ Treatment plan
___ Treatment summary
___ Academic related issues
___ Written mental health records

The purpose of the Requested Use or Disclosure is:

___ At the request of the patient ___ For continuity of care ___ For coordination of care
___ To address academic concerns ___For medical leave of absence or assessment for return
___ Other: _____

I understand that:

1. My authorization of disclosure of this information can be revoked by providing a dated and signed written revocation to Dr. Lokker. However, mental health information disclosed before the receipt of my written revocation may be used for the purposes stated above.

2. This authorization applies only to the disclosure of mental health information which exists as of today.

3. Information disclosed to a healthcare provider or health plan, in accordance with my authorization, cannot be further disclosed by the recipient without my consent, unless otherwise authorized by law.

4. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.

5. Within the provisions of the Mental Health Information Act, I have a right to review the mental health information contained in my record.

6. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment.

Expiration Date: This authorization automatically expires 365 days from today's date, unless an earlier date or event is specified: _____

Signature of Patient: **Date:** **Signature of Witness:** **Date:**

_____ _____ _____ _____

Printed Name: _____ Printed Name: _____