

Kathleen A. Jacobson, Ph.D.
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Authorization Form

This form, when completed and signed by you, authorizes Dr. Jacobson to release or obtain protected information from your clinical records.

Name(s) _____ DOB: _____

I authorize my psychologist, **Kathleen A. Jacobson, Ph.D., L.P.** to release / obtain the following information:

- | | |
|--|--|
| <input type="checkbox"/> Summary of history / diagnostic interview | <input type="checkbox"/> Clinical impressions and observations |
| <input type="checkbox"/> Discharge summary and diagnosis | <input type="checkbox"/> Personal observations |
| <input type="checkbox"/> Reports of psychological testing | <input type="checkbox"/> Psychotherapy notes |
| <input type="checkbox"/> Other (specify): _____ | |

This information should only be released to / obtained from: (List name, organization, address and phone number)

I am requesting Dr. Jacobson to release / obtain 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.)

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).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address or by signing below. 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 Dr. Jacobson 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

Signature of Parent / Legal Guardian if Patient is under 18 years of age 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.

Sign / date here to revoke this authorization: _____