AUTHORIZATION TO RELEASE INFORMATION

CHARLES A. SCHAEFER, PH.D., INC.

919-357-7203 Fax: Charlie@CharlieSchaefer.com

Name_____DOB_____

This form when completed and signed by you, authorizes the release of protected information from your clinical record to the person(s) you designate.

I authorize the exchange of information between _____ and the following:

1. Name_____Organization_____
   Address_____Phone_____
   City_____State_____Zip_____

2. Name_____Organization_____
   Address_____Phone_____
   City_____State_____Zip_____

Extent of information to be released includes:_____

_____

_____

This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

I am requesting this information exchange for the purpose of _____.

This authorization will remain in effect for two years unless you designate a different time period below. You may revoke this authorization at any time by giving us written notice. I understand that I have the right to revoke this authorization at any time unless action has been taken in reliance upon it.

Expiration if different from above: _____

This authorization is fully understood and is voluntarily made on my part.

_____ *OR* _____

Patient's Signature *Parent or Legally appointed representative's signature*

_____ _____

Date of Signature *Relationship if not parent*

Witnessed By: _____

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.