Melanie Johnson, Ph.D.

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AUTHORIZATION FORM

This form when completed and signed by you, authorizes others to release protected information from your clinical, educational and/or medical records to me.

I authorize my psychologist, Melanie Johnson, Ph.D., to speak with the following individuals and organizations about _____. Information to be disclosed may include health, educational, behavioral, social, and psychological functioning:

_____

_____

_____

_____

I am requesting my psychologist to gather this information for the following reasons, and subject to the following limitations:

_____

_____

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):

_____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my psychologist's office address. However, my revocation or modification will not be effective until my psychologist receives it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPPA Privacy Act.

_____
Signature

_____
Date