Lisa A. Wuyek, Ph.D.

Center for OCD and Anxiety-Related Disorders
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AUTHORIZATION TO RELEASE/RECEIVE INFORMATION:

This form, when completed and signed by you, authorizes Dr. Wuyek to receive, release, or disclose protected information from your clinical record to the person you designate.

I, _____, DOB _____,
(Print Full Name) (Date of Birth)

authorize Lisa A. Wuyek, Ph.D to release/receive:

_____ Billing Information _____ Treatment Plans _____ Initial Evaluation
_____ Discharge Summary _____ Verbal Communication _____ Progress Notes
_____ Other _____

This information should be **released to/received from**: _____
(Print Name)
Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

I am requesting my therapist to release/receive this information for the following reasons:
_____ Coordination of Care _____ Continuity of Care _____ Other _____

I understand that my therapist cannot re-disclose information received from another health care provider unless that other provider permits it.

You have the right to revoke this authorization in writing at any time by sending a written notification to Dr. Wuyek. However, your revocation cannot be retroactive, and the revocation will not be effective 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 information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Expiration Date: _____ End of treatment _____ Date Specified: _____

_____ _____
Signature **Date**

_____ _____
Print Patient Name **Patient's Date of Birth**