GINGER ARNOLD, PHD

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Authorization for Release of Records

This form authorizes Dr. Arnold to release and exchange protected health information from your clinical record to people specifically designated by you.

Patient Name

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____ DOB___

I authorize Dr. Ginger Arnold, and/or her assistant, who handles the release of her records, to release and/or exchange information about my neuropsychological or psychological history, conditions, test results, examinations, and status. This may include information regarding my drug and alcohol history, mental health treatment and conditions, and/or HIV/AIDS or Huntington's disease status.

This information may be released to and exchanged with the following doctors, hospitals and/or others:

Referring doctor:	
Doctor's phone number:	_ Doctor's fax number:
PCP:	
PCP's phone number:	_ PCP's fax number:
Other:	
Phone number:	Fax number:
Other:	
Phone number:	Fax number:

I am authorizing release and exchange of this information *at my request* and of my own free will. This authorization shall remain in effect: *until I withdraw my permission to release and exchange this information in writing*, or other:

I have the right to revoke this authorization, in writing, at any time by sending written notification to Dr. Arnold. However, my revocation will not be effective to the extent that Dr. Arnold has already 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 a psychologist 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 re-disclosure by the recipient of my information and no longer be protected by the HIPAA Privacy Rule.

Signature of Patient

Date

Signature of Patient's Authorized Representative Date A description of such representative's authority legally to act for the patient must be provided if the authorization is signed by a personal representative of the patient