Records Release

T. Michael Knack, Ph. D.

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize my psychologist, T. Michael Knack, Ph. D (4901 Towne Centre, Suite 205, Saginaw, MI 48604 (989) 921-5715), and/or her administrative and clinical staff to release or obtain medical and/or other information contained in its records regarding:

Client: _____ **Date of Birth:** _____

To/from the individual and/or organization listed below, subject to the conditions specified below: This information should only be released to/from (Individual and/or Organization to whom disclosure is authorized):

_____

PER H.I.P.P.A. GUIDELINES ONLY 1 DOCTOR/PERSON PER RELEASE

1. Specific type of information to be disclosed: Diagnosis, Treatment, and Exchange of Information, and or:

Circle: Diagnosis and Treatment

or other: _____

2. I am requesting my psychologist to release or 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.")

Circle: At the Request of the Individual

or other: _____

3. This authorization for release of information will expire as soon as this specific request has been fulfilled.

4. You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. 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 have a legal right to contest a claim

5. I understand that my 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.

6. 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.

Signature: _____ **Date:** _____
(When appropriate, my relationship to client is ___ parent ___ guardian)

Witness: _____ **Date:** _____
(We will witness this document at the office)

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.

_____