Elizabeth Ellis Ohr, Psy.D.
5 Market Square, Suite 3
Portsmouth NH 03801
603-828-9228

AUTHORIZATION TO & FOR RELEASE OF HEALTH INFORMATION

Today's Date:____________________________

CLIENT INFORMATION:

Name: ____

Address: ____

City, State, Zip: ____

Date of Birth (mm/dd/year): ______________ _

PARENT/LEGAL GUARDIAN INFORMATION (if applicable):

Name: ____

Address: ____

City, State, Zip: ____

- I, or my legal representative, request that health information regarding my care or treatment be released to the Elizabeth Ellis Ohr, Psy.D. at the above address. This authorization may include disclosure of information relating to alcohol and/or drug abuse, mental health treatment and/or assessment of a general medical condition.
- The recipient of this information is prohibited from re-disclosing this information without my authorization unless required by state or federal law.
- I retain the right to revoke this authorization at any time in writing to Elizabeth Ellis Ohr, Psy.D.. I understand that I may revoke this authorization except to the extent of actions that have already taken place based on this authorization. I understand that I have the right to request a copy of the authorization at any time.
- I understand that signing this authorization is voluntary. My treatment and payment will not be conditioned upon my authorization of this disclosure.
- **By signing this form I am authorizing Elizabeth Ellis Ohr, Psy.D. to communicate with the individual or organization indicated below:**

Name of Authorized Person:____

Address:____

Telephone number:____

☐ I agree to allow Elizabeth Ellis Ohr, Psy.D.to share information with this individual or organization

☐ I agree to allow this individual or organization to share information with Elizabeth Ellis Ohr, Psy.D.

INFORMATION TO BE RELEASED OR DISCUSSED:
Please place a check mark next to the information that is being authorized to be released.

☐ Client's psychiatric diagnosis

☐ Psychological evaluations and/or information regarding psychological testing

☐ Information regarding alcohol / drug treatment

☐ Information regarding psychological treatments

☐ Medical record information regarding a general / chronic medical condition

☐ Information regarding school performance

☐ Other:____

PURPOSE OF THIS RELEASE:

☐ At the request of the client

☐ At the request of the therapist

☐ Other:____

EXPIRATION OF AUTHORIZATION:

This authorization will expire 12 months from today (______________________) if not
Date (mm/dd/yyyy)
otherwise indicated here____

NOTICE:
Elizabeth Ellis Ohr, Psy.D. and other organizations are required to keep your psychological and health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential it may no longer be protected by state or federal confidentiality laws.

____________________________ ____________________
Signature of client or legal representative *Date of signature*

____
Printed name of client

______________________________ ____________________
Signature of witness *Date of signature*

____
Printed name of witness