Benna Z. Sherman, Ph.D,
Licensed Psychologist
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Authorization to Release Protected Health Information

Patient's Name____
Date of Birth_____________________
I authorize my psychologist, **Benna Z. Sherman, Ph.D**., to release/receive (circle one) the following information. Check one or more:
treatment records ___, evaluation reports ___,
academic/educational records ___, impressions and observations ___, other ___
to/from:
Name of sending/receiving party_______________________________________
Address ____
____
Phone number _______________________**Fax** __________________

___ Initial here to authorize Dr. Sherman to speak by telephone with the person named above about any information that can assist with my treatment.

Purpose of release (if you are my patient, you may if you wish write simply, "at my request") ____

I understand that my psychologist cannot redisclose information received from another health care provider if that person requested that the information not be redisclosed. I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the *recipient* of your information and no longer protected by the HIPAA Privacy Rule.

This consent expires upon completion of purpose and delivery of the material requested or upon termination of service, whichever come first, or at the end of 1 year. This consent can be revoked at any time by sending such notification, in writing, to Dr. Sherman. Your revocation will not be effective to the extent that I have taken action in reliance on the authorization.

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.

____ ______________________
signature date

(9/15)