TAPESTRY

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Authorization For Releasing Information

THIS FORM WHEN COMPLETED AND SIGNED BY YOU, AUTHORIZES ME TO RELEASE PROTECTED INFORMATION FROM YOUR CLINICAL RECORD TO THE PERSON YOU DESIGNATE.

I authorize my therapist,

_____ ,

and/or the administrative and clinical staff of Tapestry Psychological Associates to release the following information

This information should only be released to *(name and address of recipient of information)*

I am requesting that my therapist release this information for the following reasons *("at the request of the individual" is all that is required if a client does not desire to state a specific purpose.)*

This authorization shall remain in effect until *(expiration date)*

or until *(event relevant to purpose of release).*

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 has a legal right to contest a claim.

I understand that my therapist may not condition mental health services upon my signing an authorization unless the 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Client

Date

Signature of Client

Date

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.