AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize A. Robin Aylor, Ph.D. to release or receive health information to/from:

_____
Name of person or facility to receive health information

_____
Specify name/title of person to receive health information

_____
Street or P.O. Address

_____
City /State/Zip Code

_____
Telephone/ Fax Number Extension

Type of Record

☑ Mental Health

Information to be Released

- □ Billing Statements
- □ Medical Information
- □ Drug and Alcohol Abuse Information
- □ Progress Notes
- □ History
- □ Diagnosis and Prognosis
- □ Outpatient Clinic Record

□ Other (specify) _____

The purpose of this release is:

✓ at the request of the patient/ patient representative

☐ other (state reason)_____

Dr. Aylor is required by law to keep your 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.

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for 1) conducting research related treatment 2) to obtain information in connection with the eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.

I may revoke this authorization at any time, provided that I do so in writing.

The revocation will take place when Dr. Aylor receives it, except to the extent that others may have already relied on it.

I am entitled to receive a copy of this authorization.

Expiration of Authorization

Unless otherwise revoked, this authorization is ongoing throughout the duration of treatment plus one year after the completion of treatment.

Signature

_____	_____
Signature of Patient or Patient's Legal Representative	Date
_____	_____am/pm
Printed name	Time