Maura D. Sullivan, Psy.D

Authorization to release information

Patient Name:_____ Date of Birth:_____

I hereby authorize: **Maura D. Sullivan, Psy.D**
15 N. Main Street, # 9
Wolfeboro, NH 03894
Phone/Fax: 603-569-4776

To disclose the above named individual's health information as described below:

Date(s) of Service Requested (if know):_____

Description of information to be release: (check all that apply)
_____Verbal Exchange of Information _____Written Exchange of Information
_____Initial Evaluation _____Progress notes _____Termination Summary
_____Testing (date/type_____)
Other:_____

This information may be disclosed to and used by the following individual or organization:
(Please fill in where you would like the information sent)

_____

Name Address City State Zip
Telephone Number_____ Fax Number_____

Description of purpose of the use and/or disclosure:
_____Continuing care _____Consultation _____Legal purposes
_____Personal use _____Other:_____

OR: I hereby authorize:_____
_____
_____
_____

To disclose information regarding the above named individual to Maura D. Sullivan, Psy.D at PO Box 218, Wolfeboro, NH 03894. 603-569-4776

Description of information to be release: (check all that apply)
_____Medical record (entire) _____Academic record, transcript, testing
_____Medication list _____Consultations
_____Verbal Exchange of Information _____Written Exchange of Information
_____Other:_____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____. (date or event)

I understand that I may revoke this authorization at any time by notifying the facility from which I am requesting my health information. I understand that if I revoke this authorization I must do so in writing and the written revocation must be singed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of patient Date

_____ _____
Signature of patient representative Date

_____ _____
Printed name of patient representative Relationship to patient

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Revocation of authorization:

As of _____, I hereby revoke the authorization to share my medical record with _____.

_____ _____
Signature of patient Date

_____ _____
Signature of patient representative Date

_____ _____
Printed name of patient representative Relationship to patient