Suzanne Womack Strisik, Ph.D. 1050 Larrabee Ave, Ste 104-381 · Bellingham, WA 098225

Licensed Psychologist Phone: (907) 868-7843
suzanne@strisik.com

Authorization For Release of Protected Health Information

Regarding the Protected Health Information (PHI) of: _____

This form when completed and signed by me, authorizes:

[ ] The professional on this letterhead to release PHI to the person or organization as indicated below.

[ ] The person or organization to release PHI to the professional on this letterhead as indicated below.

Type of PHI to be exchanged:

Verbal: [ ]Yes [ ]No - [ ]Any Information [ ]Only:_____

Written: [ ]Yes [ ]No - [ ]All Records [ ]Only:_____

I understand that this information may contain references to mental health, substance abuse, and/or HIV.

Person and/or organization that will receive and/or release the indicated information:

_____

_____

_____

I am requesting the release of this information for the following reasons ("at my request" is all that is required if you do not desire to state a specific purpose):

[ ] at my request [ ] treatment coordination or planning

Other: _____

This authorization shall remain in effect until (check one):

[ ] Revoked by me in writing

[ ] Until (fill in an expiration date or an event): _____

You have the right to revoke this authorization, in writing, at any time by delivering such written notification to me. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage.

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.

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 privacy laws.

_____ _____ _____

Signature of Patient or Representative Date Printed Name

_____

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 (e.g., parent, legal guardian, etc.).