Coastal Psychology & Education Associates, LLC
32828 Reba Road, Suite A, Millville, DE 19967
Phone: 410-208-4784, FAX (855) 201-7322

AUTHORIZATION FORM

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 psychologist/psychotherapist, **Coastal Psychology and Education Associates, LLC** and/or administrative and clinical staff (cross out if not applicable) to release

_____

This information should only be released to (name & address of person to whom the information is to be released: _____

_____

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

_____ I understand that my psychologist cannot re-disclose information he/she received from another health care provider if that health care provider requested that the information not be re-disclosed.

This authorization shall remain in effect until (fill in expiration date - may not exceed one year) or until (fill in an event that related to the individual or the purpose of the use or disclosure -- may not exceed one year). _____

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 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 re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Client/Guardian 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.

Coastal Psychology & Education Associates, LLC
32828 Reba Road, Suite A, Millville, DE 19967
Phone: 410-208-4784, FAX (855) 201-7322

My signature below verifies that I have received the following and agree to the terms therein:

- **Delaware Notice Form - HIPAA**
- **Psychotherapist-Client Services Agreement (which includes Policy for Emergencies or Suicide Threats)**

Printed Name of Client: _____

_____ _____
Client/Guardian Signature Date

_____
Witness