Lake Norman Psychological Services, PLLC
Jennifer Sadoff, Ph.D.
9820 Northcross Center Court
Huntersville NC 28078
(704) 677-2652

Authorization Form

I authorize Jennifer Sadoff, Ph.D. and/or her administrative staff to release/exchange information in written, oral, or electronic format including demographic information, results of assessments, diagnoses, treatment notes, treatment recommendations and plan, discharge summary, and other clinically relevant information as necessary to the following:

This information should only be released to (name, address, and telephone number of the person or organization to whom the information is to be released):

_____

_____

I am requesting my therapist to release/share 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.)

At the request of the individual (check) _____ or _____.

This authorization shall remain in effect for one year from date of signature or _____.

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 generally may not condition therapeutic 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 my information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed unless provided for under the act. In addition, alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R. Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, communicable disease(s), alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing, this disclosure will include that information.

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.

_____ _____
Patient's Name Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Relationship to Patient (if applicable)

I hereby request that this authorization to disclose health information be rescinded, effective _____(date).
I/Patient/Personal Representative (circle one) understand(s) that any action taken on this authorization prior to the rescinded date is legal and binding. _____.
Signature and date