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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
RELEASE OF INFORMATION

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 Kathryn G White, PhD
Please print full name of adult client or parent/guardian of minor child

to release protected health information concerning professional services received by myself

(or my minor child or legal charge ______________________________________)

Please check one_______ To release any applicable billing and health information.
_______ To release only diagnosis and treatment recommendations.
_______ To release only billing information.
_______ To release only health information.

Any other comments:
____

This information should only be released to:

____
full name of individual, professional or agency receiving information (please print)

____

____

____
address and/or phone number/ fax or email of professional or agency receiving information

for the purpose of:____

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire (1) year after I have terminated treatment.

____ ____________________
Print name of Patient or Guardian Date of Birth

____ ____________________
Signature of Patient or Guardian Date