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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
HEALTH PROVIDER NOTIFICATION

I _____ authorize Kathryn G White, PhD

Please check one_____ To release any applicable mental and medical health information to the health provider listed below, in order to coordinate treatment.

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 ID Number (if known) Date of Birth

_____ _____
Signature of Patient or Guardian Date

Physician's Name _____ Telephone _____

Specialty or Condition Treated _____

Address _____

The above patient has consulted with me. I hope that the following information will be helpful in coordinating this patient's care. Please call if further information would be helpful.

Date of initial consultation _____ Session frequency: weekly / biweekly / monthly / as needed / none

Diagnoses and/or presenting problems _____

_____

Treatment recommendations_____

_____

Medication and other Mental Health provider as reported by patient _____

_____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and./or state law. If the records are so protected, Federal Regulation (42CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.