Child, Adolescent,
Adult, and Family
Psychotherapy

Diagnostic
Psychological
Assessment

Dr. Sheri M. Siegel
Licensed Psychologist

Authorization Form to Obtain Information

Patient Name: _____

This form, when completed and signed by you, authorizes your psychologist to obtain and/or release protected information from your clinical record from the person you designate.

I authorize **Dr. Sheri M. Siegel** to obtain and/or release the following information (provide a specific description of the information that you want disclosed) _____
_____.

This information should only be released by (name and address of person from whom the information is to be obtained)

Name: _____
Address: _____
_____

I am requesting **Dr. Siegel** to obtain 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.)

_____
_____

This authorization shall remain into effect until one year from the date below unless otherwise specified. 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient, Parent, or Legal 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.

Telephone: (770) 428-7395
Fax: (770) 428-1964
Email: drsheri@outlook.com
Web: https://www.drsherisiegel.com