Kathleen A. Jacobson, Ph.D.
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Authorization Form

This form, when completed and signed by you, authorizes Dr. Jacobson to release or obtain protected information from your clinical records.

Name(s) _____ DOB: _____

I authorize my psychologist, **Kathleen A. Jacobson, Ph.D., L.P.** and _____, at _____ to exchange to exchange the following information:

☐Summary of history / diagnostic interview ☐Clinical impressions and observations
☐Discharge summary and diagnosis ☐Personal observations
☐Reports of psychological testing ☐Psychotherapy notes
☐Other (specify): _____

The purpose of such disclosure:
Ongoing Treatment_____ Medical Care_____ Consultation_____
Evaluation_____ Transfer_____ Legal issues_____
Coordination of Care_____ Health Benefit Utilization_____ Other _____

The designated information about me ( ) may ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms.

Dr. Jacobson and the above designated person ( ) may ( ) may not discuss by telephone the content of the information released.

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address or by signing below. 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 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 Date

_____ _____
Signature of Parent / Legal Guardian if Patient is under 18 years of age 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.

Sign / date here to revoke this authorization: _____