Veronica Lichtenstein LMHC
LET'S TALK ABOUT IT

Authorization Form
(please check all applicable boxes)

☐ 1. I am completing this form to allow the use and sharing of protected health information about:

__________________________________ __________________________
Patient's Name Date of Birth

☐ 2. I authorize VERONICA LICHTENSTEIN LMHC, the administrative staff, and VERONICA LICHTENSTEIN

3. To obtain ☐ or disclose ☐ the following information:

Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.

Billing Records

Other ____

☐ 4. To the following person or organization:
From the following person or organization:

Name: ____
Address: ____
____
Phone number: ____
Fax Number: ____
Patient's relationship to this person: ____

☐ 5. This release shall permit my therapist VERONICA LICHTENSTEIN LMHC to speak directly to the party or organization named in Paragraph 4 concerning my care as provided Paragraph 3 of this Authorization.

☐ 6. I understand and agree that this Authorization will be valid and in effect until ____ / ___ / ____ (enter a date upon which this Authorization expires.) I understand that after that date no more of this information can be used or released to the person or organization unless I sign a new Authorization.

☐ 7. I understand that I can revoke or cancel this Authorization at any time by sending a letter to VERONICA LICHTENSTEIN. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

e Talk@VeronicaListens.com w VeronicaListens.com p 561.903.TALK (8255) m 1234 Address Jupiter FL 33000

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☐ 8. I understand that my therapist 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.

☐ 9. 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 or his/her Personal Representative   Date

____ _____________________________

Printed Name of Patient or Personal Representative   Relationship to Patient

____

Description of Personal Representative's Authority

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