Sandra V Heinsz, Ph.D
Confidential Information Release Authorization

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate. Please print.

I _____ (print client name) authorize my psychologist, Dr. Sandra Heinsz, and her administrative and clinical staff to release the following (Provide detailed description; if guardian, state child's name and DOB):_____
_____
_____

This information should only be released to (name and address of person to whom the information goes):
_____
_____

I am requesting my psychologist to release 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).

_____

I authorize _____
_____
to release information to Dr. Heinsz regarding me (or my ward). I want information to be shared one way only _____ (please initial)/ mutually _____(please initial).

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).
_____

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Heinsz. However, my revocation will not be effective to the extent that (1) Dr. Heinsz has already taken action in reliance on the authorization; or (2) 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 make signing a release of information a condition of my receiving psychological services, 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 re-disclosure by the recipient of my information and no longer is protected by the HIPAA Privacy Rule once it leaves Dr. Heinsz's office.

_____ _____ _____
Signature of Patient Date Self / Guardian

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.