Benna Strober, Psy.D.
Licensed Psychologist
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RELEASE OF INFORMATION/AUTHORIZATION

I authorize Benna Strober, Psy.D. to exchange my protected health information or my protected health information or that of my child (whichever is applicable) to the person(s) designated below (i.e., physician, pediatrician, school official, relative, etc):

Name:_____

Title:_____

Address:_____

Telephone:_____

Fax:_____

( ) I do not wish my primary care physician or my child's pediatrician (whichever is applicable) be contacted.

By signing below, I am authorizing the exchange of information related to my diagnosis, treatment, and progress for the purpose of coordinating treatment.

This authorization will remain in effect for one year from the date below or until treatment is terminated. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Benna Strober, Psy.D. However, I understand that my revocation will not be effective to the extent that Dr. Strober has taken action in reliance on the authorization or if my 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 this authorization may be subject to redisclosure by the recipient of this information and no longer protected by HIPAA or any other federal or state law.

I understand that Benna Strober, Psy.D. will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Print Name of Patient Relationship to Patient