Authorization to Disclose Protected Health Information

I hereby authorize **Beth Hollander, Ph.D.** ("Provider") to disclose to (name and/or function of the person or entity to whom disclosure is to be made) _____ _____ ("Recipient") the following protected health information:

____ Entire File	____ Psychotherapy Notes	____Session Start/Stop Times
____ Diagnosis	____ Treatment Plan	____ Symptoms
____ Prognosis	____ Progress to Date	____ Clinical Test Results
____ Modalities & Frequencies of Treatment Furnished		____ Dates of Treatment
____ Other _____		

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:
_____
_____

The specific uses and limitations on the uses of my health information by Recipient are as follows: _____
_____

I understand that Provider cannot condition treatment upon me signing this authorization.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable New York law.

Provider is authorized to disclose the protected health information specifically listed above until: _____ (authorization expiration date).

By: _____ Date: _____
(Patient or Patient's Representative*)

* If signed by other than Patient, please indicate the relationship between Patient and his/her Representative: _____