CENTER FOR POSITIVE CHANGE, LLC

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MT License # PSY 2553; WA License # PY 2910

RELEASE OF INFORMATION AUTHORIZATION FORM

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

I authorize my psychologist, Timothy D. Berry, Ph. D., to release the following: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

_____

This information should only be released to: (Provide name or function and address of person to whom the information is to be released)

_____

_____

I am requesting my psychologist to release this information for the following reasons, and subject to the following limitations: ("At the request of the individual" is all that is required from the patient if he/she does not desire to state a specific purpose.)

_____

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 that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my psychologist's office address. However, my revocation or modification will not be effective until my psychologist receives it.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in Sections I through III of the Notice form provided by my psychologist, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, my psychologist may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) 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 this authorization may be subject to re-disclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

_____

(If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.)