MICHELE BOGRAD, Ph.D.

Licensed Psychologist

16 Webber Avenue Bedford, MA 01730

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Authorization for Release of Information

(HIPAA compliant)

Client Name: _____

Address: _____

Authorization for release of information to:

Name_____

Address_____

Telephone_____

The information to be released or received includes:
[ ] intake summary/report [ ] discharge summary/report [ ] confirmation of services
[ ] entire psychological record [ ] treatment summary
[ ] other _____

The information is to be disclosed for the purpose of:
[ ] Evaluation or Diagnosis
[ ] Continuity of Care/Coordination of Services

By signing this form, I request and authorize you to release my protected health information from your clinical record to Michele Bograd, Ph.D. I also request and authorize Dr. Bograd to release protected information to you if she deems this to be useful for the purposes of my treatment, including evaluation or diagnosis and continuity of care and coordination of services. This information may be shared in written, electronic and/or verbal form, so long as HIPAA compliant privacy safeguards are in place. I further authorize both you and Dr. Bograd to consult with each other on an as needed basis for my treatment.

Effective Period:

_____ one year from date signed below

_____ Other (specify date/event) _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a letter to Michele Bograd, Ph.D. to her correspondence address 16 Webber Avenue Bedford, MA 01730. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest a claim.

I understand that I do not need to sign this authorization in writing at any time. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services unless the psychological services are provided to me for the purpose of creating health information for a third party and authorization is necessary to make the disclosure.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA privacy regulation.

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

I agree that a photocopy of this release shall be as valid as the original.

Client name_____
Print Name DOB

_____
Sign Name Date

Client name_____
Print Name DOB

_____
Sign Name Date

NOTE: If this form is being filled out by someone who has the legal authority to act for client (such as a parent of a minor child) please:
Print the name of person filling out this form: _____

Signature of person_____

Describe how signer has legal authority_____