

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Name: _____ DOB: _____ SSN: _____

This authorizes Brian C. Hocking, Ph.D. to _____ send to and/or _____ receive from:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

The following information: () Evaluation
() Treatment
() Other _____

For the purpose of: () Coordination of care
() Other _____

I DECLINE TO AUTHORIZE BRIAN C. HOCKING, PH.D. TO COMMUNICATE WITH MY PRIMARY CARE PHYSICIAN.

Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by my written consent, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified. No one may re-disclose this information without my permission. However, I am aware that once protected health information is copied and released, it is possible for this information to be re-disclosed by the organization that receives it, and Brian C. Hocking, Ph.D. cannot be held liable if this occurs.

This space may be used for any limitations or restrictions regarding this release: _____

Date of Signature

Signature of Patient

Relationship to Patient

Signature of guardian or next-of-kin in cases of minors or those declared incompetent.

Signature of Witness

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