Dana A. Max, Psy.D.
Licensed Clinical Psychologist
(303) 347-8498 (office)

5860 South Curtice Street
Littleton, Colorado 80120
(303) 347-2011 (facsimile)

Authorization Form

This form, when completed and signed by a client or client's legal guardian, authorizes Dr. Max to release and/or obtain protected information from the client's clinical record to and/or from the person designated.

Patient Name: _____ Patient Date of Birth: _____

I, _____ (print name), authorize Dana A. Max, Psy.D. to release or obtain the following information (describe the information you want shared; be as specific & detailed as possible):

_____
_____
_____

This information should only be released to or obtained from (name, address and phone number of the person to whom the information is to be shared):

_____
_____
_____

I am requesting Dr. Max release or obtain this information for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

_____
_____

This authorization shall remain in effect until six months of the date signed below or until (fill in an event that relates to the individual or the purpose of the use or disclosure):

_____

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Max's office address. However, the revocation will not be effective to the extent that Dr. Max has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Max generally may not make signing an authorization a condition of providing psychological services unless the psychological services are provided 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 redisclosure by the recipient of the information and is no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature of Witness Date

Relationship to Patient: _____