Dr. Heather Therapy, PLLC
1829 East Franklin Street, Unit 100H
Chapel Hill, NC 27707
919-228-9227

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client: ___________________________________ DOB: _____________________
Address: ____
Name of person signing this release, *if other than patient*:___________________________________
Relationship to client (circle one): Parent /Legal Guardian of Child/Legal guardian of adult

1. I authorize the release of information from my medical record at Dr. Heather Therapy, PLLC to the following entity____
____.

2. I authorize the following entity to release information from my medical record or other records to Dr. Heather Therapy, PLLC:____
____.

3. I authorize the release of the following information (circle yes or no and initial):

____Yes No Treatment summary, medical history, and history of contact, written or verbal
____Yes No Clinical impressions and recommendations, verbal
____Yes No Psychological testing report
____Yes No Academic record and school behavior report, written or verbal
____Yes No Diagnosis, prognosis, and treatment plan
____Yes No Ongoing report of treatment progress
____Yes No Other (please provide detailed description of information to be released)
____

4. I am requesting that this information be released for the following reasons (circle yes or no):

Yes No At the request of the individual signing below.
Yes No For treatment planning and coordination.
Yes No Other: ____.

5. This authorization will remain in effect for one year from the date of signing or until the date or event specified here: ____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Heather Therapy, PLLC. Such revocation, however, will not be effective to the extent that action has been taken 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. Heather Therapy, PLLC will apply the HIPAA Privacy Rule and the highest professional standards in order to protect any information disclosed to Heather Norman-Scott, PhD. I also understand that Heather Norman-Scott, PhD cannot control the privacy of any other entity involved in this authorization.

_______________________________________ ____________________________
Signature of Client or Responsible Party Date