David Woodsfellow, PhD
Authorization to Release Information

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

I authorize _____

To release information for planning therapy to/from

David Woodsfellow, PhD
Licensed Psychologist
The Woodsfellow Institute for Couples Therapy
2801 Buford Highway NE, Suite 295, Atlanta, Georgia 30329
tel 404-325-3401 fax 404-325-2897

I am requesting the person I designated above to release and receive this information

At my request

This authorization shall remain in effect until ***couples therapy is terminated and completed***

or until _____ *(fill in expiration date)*

***

You have the right to revoke this authorization, in writing, at any time, by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have already taken action in reliance on the authorization.

I understand that my designee generally may not condition services upon my signing an authorization unless the 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 the authorization may be subject to re-disclosure by the recipient of information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____
Print Your Name

Revised: November 2011