Amanda K. Norris, Ph.D.

1560 West Bay Area Blvd., Suite 270, Friendswood, TX 77546
Ph: (281) 480-0200 Fax: (281) 480-0202

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

______________________________ ______________ ______________________

Client/Patient Name (print) **Date of Birth** **Social Security Number**

I hereby authorize:

____

Amanda Norris, Ph.D.
1560 West Bay Area Blvd., Suite 270
Friendswood, TX 77546
Phone: 281-480-0200
Fax: 281-480-0202

_____ To Disclose To

_____ To Receive From

Name of medical professional or facility (please print):

____

Address: ______________________________________

City/State/Zip:__________________________________

Phone:________________________ **Fax:**____________________

my health information as listed below, which may include information concerning mental illness, chemical or alcohol dependency, personal history, treatment, or any such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity as defined under federal privacy regulations, the disclosed information, except chemical dependency information, may no longer be protected by federal privacy regulations.

Date(s) of service (if known):____

Description of information to be disclosed: (check all that apply)

_____ Assessments _____ Personal History _____ Educational _____ Psychological Evaluation

_____ Service/Treatment Plans _____ Financial/Billing _____ Clinical _____ Laboratory Reports

_____ Diagnosis _____ Progress Notes _____ Vocational _____ Other (specify):

____

Description of the purpose of the use and/or disclosure:

_____ At client's request _____ Legal proceedings _____ Determine eligibility-Social Security Disability, etc.

_____ Continuity of treatment _____ Financial / Insurance verification

_____ To aid in treatment planning _____ verification of maintaining appointments

Other (specify)________________________

Type of Disclosure: _____ Paper copy _____ Verbal _____ Verbal & paper copy _____ Electronic _____ Inspect/View

I understand that this authorization will expire within one year from today's date unless I specify otherwise. I desire this authorization to be in effect until ____________________________.

I understand that I may revoke this authorization at any time by notifying Amanda K. Norris, Ph.D. in writing. I also understand that the written revocation must be signed and dated later than the date of this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

____ ______________________________

Signature of Client/Patient or his/her Legal Authorized Representative Date

____ ______________________________

Printed name of Client/Patient or his/her Legal Authorized Representative Representative's relationship to Client/Patient

A PHOTOCOPY OR FAX TRANSMISSION IS AS VALID AS THE ORIGINAL