Judith Mazza, Ph.D., PA
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Licensed Psychologist

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Authorization to Release Protected Health Information

Check one: ☐ Source of Information ☐ Recipient of Information

Person or facility: ______________________________

Address: ______________________________

______________________________ Phone: ______________

A. Identifying information about me/the patient

Name: ______________________________

Address: ______________________________

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Phone: ______________ Date of Birth ______________ Social Security #, ______________

Parent/guardian (if applicable): ______________________________

Address and phone of parent/guardian: ______________________________

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☐ **By checking this box I authorize Dr. Mazza to release my *Protected Health Information* records to the recipient listed above.**

B. I hereby authorize the source named above to send, as promptly as possible, the records listed below to Dr. Judith Mazza, Licensed Psychologist.

- ☐ All Inpatient and/or outpatient treatment records
- ☐ Psychological evaluation(s) or testing records, and behavioral observations or checklists
- ☐ Psychiatric evaluations, reports, or treatment notes and summaries.
- ☐ Academic or educational records.
- ☐ Other: ______________________________

C. I authorize the source named above to speak by telephone with Dr. Mazza about any information that can assist with my treatment. ☐

D. I understand that I may void this authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 1 year from the date I signed it.

E. I agree that a photocopy of this form is acceptable, but it must be individually signed.

F. I understand that Dr. Mazza cannot redisclose information she received from another health care provider if that health care provider requested that the information not be redisclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the *recipient* of your information and no longer protected by the HIPAA privacy rule.

G. I understand that a psychologist may not condition psychological services upon my signing an authorization unless my psychological services are provided to me for the purpose of creating health information for a third party.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

______________________________ ______________________________ ______________

Signature of client, parent or guardian | Printed name | Date

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Description of authority of the personal representative of patient signing this form

Judith Mazza, Ph.D., Licensed Psychologist, has discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

______________________________ ______________

Judith Mazza, Ph.D. | Date