

Authorization Form: *For release of information*

Bend Psychological Services
965 NE Wiest Way,, No. 2 Bend Oregon 97701
Office: (541) 388-5660 Fax: 541 388-4638

This form when completed and signed by you (signature below), authorizes the designated person or organization to release or obtain protected information for the following person:

Name(s): _____

Date of Birth: _____

Release of Information

I authorize Michael Conner, Psy.D or his staff to release the following information verbally and in writing to:

(Please Initial)

_____ Screening Information _____ Behavioral and Psychological Reports
_____ Treatment Plan _____ Psychotherapy/Counseling Notes
_____ Other: _____

I authorize _____
to release the following information verbally and in writing to Michael Conner, PsyD

(Please Initial)

_____ Screening Information _____ Behavioral and Psychological Reports
_____ Treatment Plan _____ Psychotherapy/Counseling Notes
_____ Other: _____

I am requesting this release this information for the following reasons:

_____ To provide services and care, or _____ (other purpose) _____

This authorization shall remain in effect until

Expiration date: _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked this release shall remain in effect for the period reasonably needed to complete the request. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

Print Name of Patient(s), Client(s) or Authorized person(s) (parent, guardian):

Signature of Patient(s), Client(s) or Authorized person(s) (parent, guardian):

Date _____

Representative's Authority: _____

Description of Authority: _____