

Renée Flam, LCSW, ACSW

**200 N. Greensboro Street
Carrboro, NC 27510**

**Telephone (919)406-6562
www.reneeflam.com**

Authorization Form

This form when complete and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychotherapist, Renee Flam, LCSW, ACSW to release:

This information should only be released to (name and address of person/facility to which the information is to be released):

I am requesting my psychotherapist to release this information for the following reasons (e.g., "at the request of the individual" is all that is required if you are my client and you do not desire to state specific purpose):

This authorization shall remain in effect until further notice by me in writing or until (fill in an event that relates to the individual or the purpose of the use of disclosure):

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 taken action 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 my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological 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 redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Signature of Client

Date

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided below: