DAVIS PSYCHOLOGICAL SERVICES CONSULTING, PLLC

AUTHORIZATION TO RELEASE INFORMATION

I, (name of patient) _____, (hereinafter "Patient") hereby authorize (name of psychotherapist) Toby K. Davis, Ph.D., (hereinafter "Provider") to disclose and exchange mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, psychotherapist's diagnosis of Patient, to:

I, (name of patient) _____, (hereinafter "Patient") hereby authorize (name of practitioner, psychotherapist, or agency) _____ (hereinafter "Provider") to disclose and exchange mental and physical health treatment information and records obtained in the course of treatment of Patient, including, but not limited to, notes, examinations, and diagnosis of Patient, to:

Toby K. Davis, Ph.D.
POB 696
Boonville, NY 13309

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Toby Davis, Ph.D. at **POB 696 Boonville, NY 13309** to be effective. This disclosure of information and records authorized by Patient is required for the following purpose: Coordination of treatment and collaboration of treatment efforts.

The specific uses and limitations of the types of medical information to be discussed are as follows:

PHI

Such disclosure shall be limited to the following specific types of information: **PHI**

Psychotherapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable New York law may protect such information. This authorization shall remain valid until: one year after treatment ends.

Patient's signature: _____ Date: _____

Witness signature: _____ Date: _____.

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