DAVIS PSYCHOLOGICAL SERVICES and CONSULTING

AUTHORIZATION TO RELEASE INFORMATION

I, _____ (hereinafter "Patient") hereby authorize **Toby K. Davis, Ph.D., CASAC-G** (hereinafter "Provider") to disclose mental health and substance use information and records obtained in the course of this evaluation and treatment of Patient, including, but not limited to, the diagnosis of Patient, to:

_____ **.**

I, _____ (hereinafter "Patient") hereby authorize _____(hereinafter "Provider") to disclose mental health and substance use information and records obtained in the course of this evaluation of Patient, including, but not limited to, the diagnosis of Patient, to:

Toby K. Davis, Ph.D., CASAC-G.

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 Provider at POB 696 137 Main Street Boonville, NY 13309 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose: _____ .

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:

Substance Use and Relapse Information, Prevention and Psychotherapy Addiction Treatment.

Psychologist shall not condition the evaluation/treatment/assessment/testing 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 is terminated.

Patient's signature: _____ Date: _____ .

Witness signature: ________________________________ Date: __________________.

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