Eve Merrill, Psy.D.
Licensed Psychologist

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AUTHORIZATION FOR DISCLOSURE, USE OR RECEIPT OF HEALTH INFORMATION

I_____, hereby authorize **Dr. Eve Merrill** to either receive, use of disclose the following information:

Name, phone number, email and address of individual/organization to send or receive information from:

For the following patient:

Patient Name:_____Date of Birth:_____

Nature of information to be disclosed:_____

Purpose of Disclosure: Assessment/Continuity of Care

Expiration Date: 6 months

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to Dr. Merrill at the above address, which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by Dr. Merrill.
I understand that:

A revocation does not effect health information already sent out under the authorization.
My treatment will not be based on whether I provide authorization for disclosure.
There is a potential for my *Protected Health Information* to be re-disclosed by the recipient.

Signature of Patient/Guardian Date

_____ _____