

Tanya Hartman, PhD
Clinical Psychologist
21403 Chagrin Blvd, Suite 210
Beachwood, Ohio 44122
Phone 440.384.2349
tanya@drtanyahartman.com

Authorization to Release/Exchange Confidential Records and Information

Source of Information: Name/Agency _____
Name/Agency _____
Name/Agency _____

Information Concerning: Name _____

Information Released to/
Exchanged with: Name/Agency _____
Name/Agency _____
Name/Agency _____

I hereby authorize the source named above to release/exchange confidential information listed:

The authorization is valid during the pendency of any claim or demand made by or in behalf of me and arising out of an accident, injury, or occurrence to me. I understand that I may void this authorization, except for action already taken, at any time, by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this authorization, it will automatically expire in 12 months from the date I signed it.

I understand that a psychologist 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 the information and no longer protected by HIPAA Privacy Rule. In consideration of this consent, I hereby release the source of the records from any and all liability arising therefrom. I affirm that everything in this form that was not clear to me has been explained.

Signature of Client Printed name Date

Signature of Parent/Guardian Printed name Date