Dr. Speed, Inc.
Christiane Speed, Psy.D.
Licensed Psychologist

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AUHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

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

I __________________________ hereby authorize Dr. Christiane Speed to (check all that apply):
Client/Legal Guardian Name

☐ Exchange ☐ Release/Disclose ☐ Obtain

The following health information for all dates of service:
☐ All Mental Health Records ☐ Treatment Summary only ☐ Progress/Session Notes only
☐ Other (specify) ____________________________

About _____________________________in verbal/written form for the following purpose(s):
Client Name

☐ Coordination/collaboration of care ☐ Other (specify) ______________________________

The party with whom the information may be exchanged/disclosed or obtained:

Name: ____________________________________
Contact Phone/Fax: _______________________________________
Address: ____

BY CLICKING ON THE CHECKBOX BELOW/SIGNING THIS AUTHORIZATION FOR RELEASE OF INFORMATION **I hereby state that I have read and fully understand the following and agree to the terms of this document:**

- If no date is specified, this authorization will expire 1 year from the signature date.
- This authorization is voluntary and I may revoke this authorization at any time by providing Dr. Speed with written notification and the revocation will be effective from the date of receipt by Dr. Speed. However, the revocation will not be effective to the extent that Dr. Speed has taken action in reliance on the authorization; or if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.
- The information disclosed may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule.
- I will be fully responsible for the costs associated with preparing and fulfilling the request for release of the above designated information.
- I understand that I have a right to receive a copy of this authorization and to refuse to sign this authorization.

Client Signature: ___________________________________ Date: ____________________
Legal Guardian Signature (if applicable): __________________________ Date: _____________