Fletcher
& Associates
Psychological Services, P.A.

Susan Fletcher, Ph.D. Licensed Psychologist
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Authorization for Use or Disclosure of Health Information

Patient Name ______________________ Date of Birth ______________________

I hereby authorize the release and/or exchange of information, including reports of psychological and psychiatric evaluations and/or medical, school, social and/or other appropriate records pertaining to the patient named above, between:

Fletcher & Associates Psychological Services, P.A.
2301 Ohio Drive, Suite 135
Plano, Texas 75093
Phone: (972) 612-1188
Fax: (972) 612-8040

- AND -

Name: ______________________
Address: ______________________
City, State Zip: ______________________
Phone: ______________________
Fax: ______________________

The purpose of this request is: ______________________

This authorization will expire on: Date: ____________ OR when the following occurs: ____________

A duplicate, photo static copy, or fax of this release may be used in lieu of the original.

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., mandated therapy or mandated testing), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

Date ____________ Patient Name ______________________ Patient Signature (parent or guardian if under 18) ______________________

Name of Person Signing ______________________ Relationship to Patient ______________________