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TWO-WAY AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize David W. Sprague, Ph.D. AND \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to disclose to each other the following information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Nature of the information, as specific and limited as possible):

The purpose of this authorized disclosure is to:

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(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the federal Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 150 & 164 ("HIPPA"), as well as the federal law governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and/or the New York State Mental Hygiene Law, Section 33.13. This Protected Health Information cannot be disclosed without my informed, voluntary, and written authorization unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Specific date, event, or condition upon which this authorization expires)

I understand that generally David W. Sprague Ph.D. may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstance I may be denied treatment if I do not sign an authorization form.

I understand that there is the potential for unauthorized redisclosure of this Protected Health Information by the person or organization to whom it has been disclosed.

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_