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Authorization Form

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

I authorize my psychologist, Dr. Nancy Davis, to **release/exchange** (cross out if exchange is not applicable) the following information about myself/my child (please circle). **(Please read and place a check on the line before the type of information to be released or exchanged. If not all the statement applies, cross out and put your initials beside all the information that you do not authorize for release)**

- Information about my therapy and course of treatment including/ not including written sessions notes.
- Information about evaluations done by Dr. Davis including/ not including a written report of a psychological evaluation completed by Dr. Davis.
- Information related to medical treatment and medication.
- Information about the fact that I am in therapy, how often I am seen, my attendance, and compliance with therapy.
- Other information:

This information should only be released to or exchanged with:

Name: _____

Address: _____

Phone Number: _____

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose).

This authorization shall remain in effect for one year unless I notify Dr. Davis in writing that I revoke this authorization. I know that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Davis' office address. I also understand that my revocation will not be effective to the extent that Dr. Davis has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my 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 my information and no longer protected by the HIPAA Privacy Rule.

Signature of Client or Guardian

Signature

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.