Authorization Form

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

Permission is given to: Lou A. Lichti, Ph.D.

City Park Psychological Services, LLC 209 W Patrick Street, Frederick, MD 21701

301.401.2813 lichti@verizon.net

_____to release information _____to obtain information

1. Name of Patient: _____Date of Birth_____
2. Information is to be released to and/or obtained from:

   name _____
   address _____
   telephone _____

3. Purpose or need for disclosure:_____
4. Extent or nature of information to be disclosed:

   _____

5. This is a: _____single disclosure _____continuing disclosure

6. I understand that I may revoke this consent at any time. In any event this consent expires automatically as described below.
7. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no long protected by the HIPAA Privacy Rule.
8. Signature of Patient:

   _____Date:_____

   _____Date:_____

   Parent or Guardian Signature

9. Signature of Clinician:

   _____Date:_____

10. Expiration Date: _____