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 drlou@cityparkpsychological.com

_____to release information _____to obtain information

Name of Patient: ____________________________Date of Birth________________

Information is to be released to and/or obtained from:

name ____

address ____

telephone ____

Purpose or need for disclosure:____

Extent or nature of information to be disclosed:

____

This is a: _____single disclosure _____continuing disclosure

I understand that I may revoke this consent at any time. In any event this consent expires automatically as described below.

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.

Signature of Patient:

____Date:___________________

____Date:___________________

Parent or Guardian Signature

Signature of Clinician:

____Date:____________________

Expiration Date: _______________________