MARY A. CONNELL, ED.D., ABPP
Board Certified in Forensic Psychology

Authorization to Release Protected Health Information

Name:_____DOB:_____SS#_____

I hereby authorize the release of the following protected health information:
□ Psychological treatment records
□ Medical treatment records
□ Test/evaluation results, data, or reports
□ Hospital records
□ School records
□ Other:

□ To □ From □ To □ From

Mary A. Connell, Ed.D.
100 East Fifteenth Street, Suite 635
Fort Worth TX 76102
Phone: 817-334-0035
Fax: 817-334-0297
Email: mary@maryconnell.com

Name:_____

Address:_____

_____
City State Zip

Phone:_____Fax:_____

For the purpose of: _____

The information may be provided in written, verbal or electronic format (including email and facsimile).

This authorization will expire: **90 days from date signed**

I understand and agree that I have the right to refuse to sign this authorization. I do not have to sign this authorization in order to continue to receive services (except for research-related treatment and certain Court-ordered or employment related evaluations). When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy law. I have the right to revoke this authorization except to the extent that PHI has already been disclosed in reliance on this authorization. My revocation must be submitted IN WRITING to the Privacy Officer.

My signature, below, means that I understand and agree with the above statement.

_____ _____
Signature **Date**

Relationship to individual about whom information is being disclosed:
□ Self □ Parent □Legal Representative