Dianne E. Rosen, Ph.D. **Licensed Psychologist**
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I _____
Full name of adult client or parent of minor child (please print)

AUTHORIZE:

Dr. Dianne E. Rosen
3107 Stirling Road Suite 103
Ft. Lauderdale, FL 33312

to release **protected health information** concerning professional services received by myself or my minor child or legal charge

TO:

_____
Name of professional or agency releasing information (please print)

_____
Address

_____
(Print full name of minor child)

For the purpose of: _____
(Please print-If you are a current patient, "at patient request" is sufficient)

You may revoke this consent to release protected health information at any time, by written request. Unless you revoke it, this authorization shall remain in effect for one year or until such time as specified herein:

Psychologists do not generally make signing releases of authorization of protected health information a condition of treatment unless there are clinical indications to do so (i.e., if important to talk to your psychiatrist or personal physician to coordinate our treatment efforts). Your right to revoke authorizations does not apply if the authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest the claim. **I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your protected health information and no longer protected by the HIPAA Privacy Rule. I understand all of the aforementioned and with informed consent and of my own free will, authorize disclosure of protected health information.**

_____ _____
Signature of Patient or Parent of Minor Date