NORLYDIA F. MCBEE, PH.D.
LICENSED PSYCHOLOGIST
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AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE Dr. Norlydia McBee, her agents, representatives, employees, and/or business associates to use, release, or disclose the protected health information described below to:

_____
(Name and address of person/organization to whom information should be sent) This may be the requesting health care provider.

Information to be disclosed (*check one*):

X_ All medical and psychological information about me, including medical and psychosocial history (that may include information about sexual abuse, sexual assault, abortion, or other sensitive issues); testing and test results; diagnoses, prognosis and treatment of any mental condition, including:

- Any disorder of the immune systems, including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes; Any communicable disease or disorder; Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnoses, functional status, the treatment plan, symptoms, prognosis and progress to date; and Any condition, treatment or therapy related to substance abuse, including alcohol and drugs.

___ Other (*specify*): _____

This authorization will expire (*check one only*):

X_ One (1) year from the signature date below, or
___ On (*date*) _____, or
___ On occurrence of the following event: _____

Purpose of disclosure:

X_ To disclose the information at my request
___ Other purpose (specify): _____

Special Instructions or limitations: _None_____
(if none, please write "none")

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of Dr. McBee's policies and procedures for HIPPA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns that I may have about the use or misuse of my health information with Dr. McBee. I understand that Dr. McBee, her agents, representatives, employees, and other business associates assume no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dr. McBee, her agents, representatives, employees, and other business associates from all legal liability that may arise from this authorization. I acknowledge that I have read the authorization. I agree that a photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon my request.

Name (please print): _____ **Date of Birth:** _____

Address: _____ **Telephone:** _____

Signed: _____ **Date this Authorization Executed:** _____

If the signature above is not that of the person whose medical/psychological records are being authorized to be released, I am acting for the person whose medical/psychological records are being authorized for release:

My relationship to such person is: _____ **Signed:** _____

The person whose medical/psychological records are hereby authorized for release or that person's representative may revoke this authorization by notifying Dr. McBee in writing. Federal law states that treatment, payment, enrollment, and eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is otherwise prohibited by the Health Insurance Portability and Accountability Act of 1996. Federal law also requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.