Powers Ferry Psychological Associates, L.L.C.

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Ellen Spandorfer, Psy.D.
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I hereby authorize ____ (Therapist's name)

to: ( ) release ( ) receive ( ) exchange

information concerning ____ (Name of Patient, DOB)

( ) to ( ) from ( ) with ____ .

I understand that such disclosure will be made for the following purposes:

( ) Treatment Progress
( ) Psychological Evaluation
( ) Medical Treatment
( ) Academic Placement
( ) Psychiatric Evaluation
( ) Social History
( ) Treatment Summary
( ) Diagnosis
( ) Child Custody / Visitation
( ) Competency to stand trial
( ) Other ________________
____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and, if not earlier revoked, it shall terminate on ______________________ without revocation.

I understand that disclosures may not be subject to confidentiality if the therapist becomes aware of any suicidal or homicidal thoughts or plans, or in the event that the therapist becomes aware of any form of abuse or neglect.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

________ I authorize this information to be faxed to the party indicated above, and understand the limits of
Initial confidentiality which doing so creates.

____ ______________________
Signature of Patient, Parent, or Legal Guardian Date