SANDY GRAHAM, MS, PLLC
AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize Sandy Richardson, MS, PLLC to release and disclose information from the clinical record of:_____ (_____)

(Name of client) (Date of birth)

To:

_____

(Facility/Provider)

_____

(Address)

This release is for the entire contents of any records which might be held by Sandy Richardson, MS, PLLC regarding my care including all clinical, financial and scheduling information. This release also authorizes Sandy Richardson, MS, PLLC to consult with the provider named above, and to discuss, in person or by phone, any and all aspects of my treatment and my records.

For the purposes of _____

(State specific purpose of information to be disclosed)

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to Sandy Richardson, MS, PLLC. I understand that a revocation is not valid to the extent that Sandy Richardson, MS, PLLC has acted in reliance on such authorization. This authorization is valid until _____ (If no date is specified, the authorization expires one year from the date of the signature.)

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any or none): _____.

A copy of this release shall have the same force and effect as the original.

I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

I have received a copy of the Sandy Richardson, MS, PLLC HIPPA Notice of Privacy Practices.

_____ _____

(Client Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

_____ _____

(Witness) (Date) (Relationship)