Debra Kessler, Psy.D., R.N., M.N.
Specializing in children with emotional & developmental challenges
Clinical Psychologist, LIC. PSY 19100
(818) 248-6414

Authorization Form

Re: _____
Client Name

This form when completed and signed by you, authorizes **Debra Kessler, Psy.D., R.N., M.N.** to release protected information from your clinical record to the person you designate.

I authorize **Debra Kessler, Psy.D., R.N., M.N**, A Professional Corporation and _____ to exchange information regarding: (client name) _____

This information should only be exchanged between **Debra Kessler, Psy.D., R.N., M.N.** and _____

I am requesting my therapist to release this information for the following reasons, and subject to the following limitations: ("At the request of the individual" is all that is required from the patient if he/she does not desire to state a specific purpose.): _____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure): _____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to my therapist/counselor's office address. However, my revocation or modification will not be effective until my therapist/counselor receives it.

I understand that my therapist generally may not condition therapeutic/counseling services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in Sections I through III of the Notice form provided by my therapist, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, my therapist may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of PHI for that research; or 2) the therapy/counseling 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 this authorization may be subject to redisclosure by the recipient of my information and may no longer be protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

(If a personal representative of the client signs the authorization, a description of such representative's authority to act for the client must be provided.)