Ackerson & Associates
Suite 100, Magnolia Financial Center
1025 23rd Street South, Birmingham, Alabama 35205
(205) 324-8499

Joseph D. Ackerson, Ph.D. **Kimberley Svec**
Ackerson, Ph.D., ABPP
Heather M. Austin, Ph.D. **H. Randall Griffith,**
Ph.D., ABPP-CN
Kristine Lokken, Ph.D. **Lu Ann Van Detta, LPT**

Authorization Form

This form when completed and signed by you authorizes your clinician and/or office staff to release protected information from your clinical record to the person you designate.

I authorize my psychologist/clinician, _____and/or his or her administrative and clinical staff to release the following information _____
_____
_____

This information should only be released only to [please include name, address and telephone number]

_____

_____

_____

I am requesting my psychologist/clinician to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____

This authorization shall remain in effect for twelve (12) months or until_____ unless otherwise indicated by myself in writing to this office. You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that the clinician has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist/clinician generally may not condition psychological services upon my signing an authorization unless the psychological or other clinical services are provided to me for the purpose of creating health information for a third party. Such Third party examples include, but are not limited to: Individual Educational Evaluations (IEEs), referring physicians, attorneys, agencies, or other healthcare providers.

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

_____ _____
Signature of Patient Date

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.