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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize and request
(Client's Name)

_____ *at* _____
(Practitioner or School Name)

to release and obtain all pertinent confidential professional information pertaining to me (or my child) to

_____

THE PURPOSE OF THIS RELEASE IS (check one or more)

- ☐ At the request of the patient/patient representative
- ☐ Other (state reason)_____

NOTICE

Kristen Iverson Ph.D. and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Kristen Iverson, Ph.D., 1151 Dove Street, Suite 240, Newport Beach, CA 92660. The revocation will take effect when Kristen Iverson, Ph.D. receives it, except to the extent that Kristen Iverson, Ph.D. or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____*(insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.*

SIGNATURE

_____ Date**:** _____
(Signature of Patient or Patient's Legal Representative)

_____
Printed Name

_____
(*if signed by someone other than the patient, state your relationship to the patient/authority*)

_____
Witness (*only if patient unable to sign)* or Interpreter