GAYLE CORDES DBH, LPC, LISAC
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(P) 480.296.2050

AUTHORIZATION FORM

This form when completed and signed by you authorizes Dr. Gayle Cordes, LPC, LISAC to release/or request protected health information from your clinical record to the person you designate.

Client name_______________________________Date of Birth_______________

Address____
City/State/Zip Code

Phone #____

I authorize Dr. Gayle Cordes, LPC, LISAC to release/request the following:

_____ Psychotherapy Notes

_____ Telephone Contact/Consult

_____ Psychological Exam/Testing Results

_____ Treatment Summary

_____ Thank You for Referral Letter/Call

_____ Medical Records

_____ Other (specify) ____

This information should only be released TO OR FROM:

____
Name person/party/agency

____
Address

____
Telephone Fax Email

This information shall remain in effect until ________________ or one year from the date signed below.

You have the right to revoke this authorization in writing at any time by sending such written notification to Dr. Gayle Cordes, LPC, LISAC. However your revocation will not be effective to the extent that Dr. Gayle Cordes, LPC, LISAC. 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 Dr. Gayle Cordes, LPC, LISAC 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.

X____
Signature of Self, Parent or Guardian Printed Name Date