DR. VICTORIA FITZGERALD, PLLC

214.295.7615

CONSENT FOR COMMUNICATION WITH OUTSIDE PARTIES

I give my permission for Victoria A. Fitzgerald, Ph.D. of Dr. Victoria Fitzgerald, PLLC to release and receive personal health information regarding my care, evaluation and personal history for the purpose of consultation, academic planning, treatment planning, information gathering and exchange of information

_____.

(provide your name and date of birth)

Professional's Name:_____
Agency/School/Business:_____
Phone Number/Email Address:_____

Professional's Name:_____
Agency/School/Business:_____
Phone Number/Email Address:_____

Professional's Name:_____
Agency/School/Business:_____
Phone Number/Email Address:_____

Other Name (e.g., family member):_____
Relationship to Patient:_____
Phone Number/Email Address:_____

Unless otherwise revoked, this Authorization expires one year from the date signed.

I understand and acknowledge that I may revoke this Authorization at any time by providing written notice of revocation to the Custodian of Records at the address below; provided, however, that this Authorization may not be revoked to the extent to which it has been relied upon by Dr. Victoria Fitzgerald, PLLC. Any revocation must be in writing, dated and signed by the individual granting this Authorization.

In addition, I acknowledge that the person(s) authorized to receive the information as identified in Part I must maintain the confidentiality of such information in accordance with the provisions of Chapter 611 of the Texas Health & Safety Code and that such person may further use or disclose the Protected Health Information without any additional Authorization provided such use is consistent with the purpose for which it is disclosed as described in Part II. I further acknowledge that such Protected Health Information may no longer otherwise be subject to the restrictions on Use and Disclosure applicable under the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as may be amended from time to time (the "Privacy Standards").

I hereby release Dr. Victoria Fitzgerald, PLLC. from any civil or criminal liability or responsibility pursuant to Chapter 611 of the Texas Health & Safety Code and/or other applicable statutes and regulations as a result of having released the requested information pursuant to this Authorization.

I certify that this form has been fully explained to me and that I understand its contents.

_____ _____

Name & Signature of Patient Date

_____ _____

Name & Signature of Witness Date

Completed forms should be sent to:

Custodian of Records:
Dr. Victoria Fitzgerald, PLLC.
1205 S. White Chapel Blvd., Ste 285
Southlake, TX 76092

If you have questions, please contact the Custodian of Records: Phone: (214) 295-7615