DR. VICTORIA FITZGERALD, PLLC

214.295.7615

AUTHORIZATION FOR CONSENT TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

Completed forms should be submitted to the Custodian of Records shown above. Information cannot be disclosed as requested unless all parts of the form are completed and signed by the appropriate parties. You are not required to sign an Authorization in order to receive treatment.

PART I IDENTIFICATION OF CLIENT

Name: _____

Date of Birth: _____

PART II IDENTIFICATION OF PERSON(S) OR CLASS(ES) OF PERSONS AUTHORIZED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION DESCRIBED IN PART III

Dr. Victoria Fitzgerald, PLLC is authorized to **DISCLOSE AND OBTAIN** the information described below in Part III to the following individuals (please write name):

Doctor _____

Doctor_____

Counselors/Therapists_____

School/Work Personnel_____

Family Members_____

Other:_____

PART III DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE OBTAINED OR DISCLOSED

NEUROPSYCHOLOGICAL/PSYCHOLOGICAL TESTING

PART IV PURPOSE FOR WHICH INFORMATION IS REQUESTED TO BE USED OR DISCLOSED

Exchange of Information and Treatment Planning

PART V EXPIRATION OF AUTHORIZATION

Unless otherwise revoked in accordance with Part VI, this Authorization expires one year from the date signed.

PART VI REVOCATION OF AUTHORIZATION, SUBSEQUENT DISCLOSURE AND RELEASE

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 electronic mail address above; provided, however, that this Authorization may not be revoked to the extent to which it has been relied upon by Dallas Psychological Services, 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 II 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 described in Part III without any additional Authorization provided such use is consistent with the purpose for which it is disclosed as described in Part IV. 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"). Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I hereby release Dr. Victoria Fitzgerald, PLLC and Dr. Victoria A. Fitzgerald from any administrative, 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 this form has been fully explained to me and that I understand its contents.

PART VI SIGNATURES

_____ _____

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