Valerie Hoffman, Psy.D.
Assessments & Psychological Services

Authorization to Exchange Records

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

Patient Name: _____

Date of Birth: _____

I authorize my psychologist, Dr. Valerie Hoffman and/or his or her administrative and clinical staff to exchange:

- ☐ Therapy Notes
- ☐ Evaluation Report
- ☐ Psychological Information for purpose of verbal consultation with another provider

This information should only be exchanged with:

Name: _____
Office Name: _____
Phone Number: _____
Fax: _____

I am requesting Dr. Hoffman to exchange this information for the following reasons:

- Evaluation and treatment planning

This authorization shall remain in effect until _____or no longer than six months from today.

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 I have 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 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.

_____	_____	_____
Signature of Patient Or Parent, Guardian, or Personal Representative (specify)	Printed Name	Date