

**Deborah C. Neel, Ph.D.**

**Licensed Psychologist/Certified Sex Therapist**

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## Authorization Form

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

I authorize my psychologist, Deborah C. Neel, Ph.D. and/or her administrative staff to release, receive from, exchange:

This information may include:

School records, Medical Records, and Psychiatric Records.

Other \_\_\_\_\_

This information should only be released, received from, exchanged with:

Name \_\_\_\_\_

Address \_\_\_\_\_

Dr. Neel is to release, receive, and exchange this information at my request. State a specific purpose, if you choose. (not necessary)

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This authorization shall remain in effect until this client terminates treatment or if this client has not been seen in a six (6) month period.

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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name