Authorization Form

This form, when completed and signed by you, will authorize protected health information from your medical records to be released to R. Phillip Colon, Ph.D.

I authorize (Name and Address of Person and/or Facility)

to release (Description of the information that you want disclosed, e.g. summary of treatment services)

This information should only be released to:

R. Phillip Colon, Ph.D.
520 Franklin Avenue, Suite L21-I
Garden City, NY 11530
516/294-8914

I am requesting the information to be released for the following reason(s), e.g. I am being treated by Dr. Colon:

This authorization shall remain in effect until (fill in expiration date):

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. R. Phillip Colon at 520 Franklin Avenue, Ste. 215, Garden City, NY 11530. I understand that a revocation will not be effective to the extent that Dr. Colon 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 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 said information and no longer protected by the HIPAA Privacy Rule.

_____

Signature of Patient, or parent of Minor Patient, or Personal Representative of Patient

Date:

_____

Print name of Patient, or parent of Minor Patient, or Personal Representative of Patient