Allison Fagan, Psychologist LLC

Allison Fagan, PhD
6264 S. Sunbury Rd, Suite 400
Westerville, OH 43081
(614)398-9624
(614)895-2137 (fax)
allison@drallisonfagan.com

Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information.

Printed name(s) of client(s): ____

Date(s) of birth of client(s): ____

I/we authorize Allison Fagan, Ph.D. to disclose and exchange any protected health information including psychological evaluation(s), reports, assessments, treatment notes, summaries or other documents with diagnoses, prognoses, recommendations, testing records, behavioral observations and any other protected health information with:

(*This is the individual or agency that you are giving me permission to communicate with. Please print very clearly*)

____
Name and/or Agency

____
Address

____
City, State, Zip

Phone ____________________________ Fax____

Email address ____

The following modalities of communication may be used:

_____telephone _____fax _____email _____in person

This authorization is valid from the date of this signature until the completion of treatment and may be revoked by me at any time. After completion of treatment, no information can be discussed or released unless a new Authorization is signed. Neither the revocation of this Authorization nor its expiration can rescind information already released.

Signature of client____Date______________

Signature of client____Date______________