Kate M. Marshall, Ph.D., P.C.
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Boulder, CO 80304
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Authorization Form

This form, when completed and signed by you, authorizes me to request, release and/or exchange protected information from your clinical record.

I _____authorize my psychologist, Kate M. Marshall, Ph.D to request, release and/or exchange the following information assessment, treatment plan, and goals, progress in treatment or _____.

This information should only be exchanged with
_____
_____.

I am requesting my psychologist to exchange this information for the following reasons _____
_____
or _____at my request

_____This release is for one time only.
_____This authorization shall remain in effect until (date)_____or
Event _____ or
_____ until my treatment with Dr. Marshall terminates.

I have the right to revoke this authorization in writing at any time by sending such written notification to my psychologist's office address. However, my revocation will not be effective to the extent that my psychologist 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 and 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 the information and no longer protected by the HIPPA privacy rule.

Signature of Patient:_____ Date:_____

Signature of Parent:_____ Date:_____
(If the patient is a minor)