Sonja Harrison, LICSW
1555 Connecticut Avenue NW, Suite 2E
Washington, DC 20036
202-601-3200 (P) 202-697-5032 (F)

Authorization Form for Release of Clinical Record

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

Patient's Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I, _____, authorize Sonja Harrison, LICSW, to

___ Release from my record ___ Receive from my record

_____
_____
(Provide description of the information that you want disclosed on the line above. Your description should be as specific and detailed as possible.)

I am requesting that Sonja Harrison, LICSW, release information for the following reasons: ("*at the request of the individual"* is all that is required if you are my client and you do not desire to state a specific purpose.)

_____

I understand the Sonja Harrison, LICSW, cannot re-disclose information she received from another health care provider if that health care provider requested that the information not be re-disclosed.

This authorization shall remain in effect for a period of one year from the date below or until _____.

The information is to be released to/released from:

Name: _____ Position: _____

Address: _____

Phone: _____ Fax: _____

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to Sonja Harrison, LICSW. However, the revocation will not be effective to the extent that action taken is 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 Sonja Harrison, LICSW, generally may not disclose psychological services upon the signing of 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-disclose to the recipient of the information and no longer protected by the HIPAA Privacy Rule.

Patient or Legally Authorized Individual Signature: _____ Date: _____