Greg Thigpen, PsyD
Clinical Psychologist
License Psy19198

Authorization To Release Information

I, _____, (hereinafter "Client") hereby authorize Greg Thigpen,
Name of Client
PsyD ("Provider") to ❑ (send) ❑ (receive) information and records ❑ (to) ❑ (from):

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at P. O. Box 2996, Santa Rosa, CA 95405 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose: _____

_____

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to): _____

_____

Such disclosure shall be limited to the following specific types of information: _____

_____

Psychotherapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Client's signature: _____ Date: _____

Parent/guardian signature: _____Date: _____

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