Nancy R. Bryant, Ph.D, Licensed Psychologist
2008 Willamette Falls Dr., Suite 200B, West Linn, OR 97068
Phone: 503-655-3505

Authorization for Release of Protected Health Information

I, _____, authorize Dr. Nancy R. Bryant, PhD to

release the following information concerning _____ to

Name: _____

Address: _____

_____

Phone: _____ FAX: _____

I authorize the release of:

_____ The report describing my (or my child's or ward's) evaluation.

_____ Clinical information as needed for follow-up care.

_____ Selected test protocols or raw data, as needed for follow-up care.

_____ My entire file, including test protocols, case notes, raw data, & personal history information.

This authorization may revoked at any time. Unless revoked earlier, the only exception is when action has been taken in reliance on this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand that a psychologist may generally not condition the provision of psychological services on my signing of such an authorization, unless the 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 not longer protect by the HIPAA privacy rule.

Finally, I understand that my (or my child's or ward's) report may contain personal medical information (including AIDS/HIV information) and/or drug and alcohol evaluation, treatment, and assessment information, if relevant.

_____ _____
Signature Today's date

_____ _____
Nancy R. Bryant, PhD, Witness Date

PLEASE MAIL THIS RELEASE TO THE ADDRESS ABOVE!