Scott Thornton, Ph.D.
7777 Forest Lane, C-833, Dallas, TX 75230
Office: 972-566-6609 Fax: 972-566-6679

Authorization for Release of Information

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Patient Name (please print) ______________________ Date of Birth / Social Security Number ______________________

Date of Treatment (month / day / year) ______________________ Hm Phone# ______ Wk Phone# ______

I hereby authorize Scott Thornton, Ph.D. to ☐ release information to: ☐obtain information from:

____
Doctor, Hospital, Insurance Company, Attorney, etc.

Address ______________________ Telephone Number ______________________

For the purpose of: ____

Information to be Released:

☐ Psychological Evaluation ☐ Entire Chart

☐ Other (Specify): ____

☐ Verbal Communication With: ____

I understand that specific information to be disclosed may include history of *Drug or Alcohol Abuse* or *Mental Health Treatment*, information concerning communicable diseases such as *Human Immunodeficiency Virus (HIV)*, and *Immune Deficiency Syndrome (AIDS)*, laboratory test results, treatment progress, and any other such related information.

This authorization will expire 180 days from the date of my signature or condition as follows:

____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Scott Thornton, PhD.
7777 Forest Lane, C-833
Dallas, TX 75230
972-566-8025 phone
972-566-6679 fax

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I further authorize that a photocopy of this authorization is acceptable as an original.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

____ ___________________________

Signature of Patient or Personal Representative Date

____ ___________________________

Name of Patient or Personal Representative Description of Personal Representative's Authority

Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law 42 C.F.R., Part II. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of information is not sufficient for this purpose.