Sydney Felker-Ross, PhD
1150 S. Milledge Avenue, Suite 4
Athens, GA 30605
706-548-6744

Authorization Form

NAME: ________________________________ DATE OF BIRTH: _______________________

If you sign this form, confidential psychological, psychiatric, and medical information can be released and/or discussed with the people or agencies below unless noted by exclusions or limitations. Your signature indicates that you are voluntarily signing this form. Please note that you may change your mind at any time by sending written notification to this office address. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Individual(s) or agency(ies) to **release** information:

☐ **Sydney Felker-Ross, PhD**
☐ Other:
Name: ________________________________
Address: ________________________________
____
Phone: ________________________________

Individual(s) or agency(ies) to **receive** information:

☐ **Sydney Felker-Ross, PhD**
☐ Medical Insurance Carrier
☐ Other:
Name: ________________________________
Address: ________________________________
____
Phone: ________________________________

Purpose(s) for which information will be released (“at the request of the individual” is all that is required if you do not wish to indicate a specific purpose):
____
____

Information to be released:
____
____

Note any exclusions or limitation here:
____

Releasing/Receiving persons have my permission to discuss information released: ☐ Yes ☐ No

I give my permission for a faxed or photocopied signature to serve as an original regarding this release.

Date of release expiration: ____

I, hereby, authorize release of confidential information per conditions noted above. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPPA Privacy Rule.

____ ____
Client Signature Date

____ ____
Parent/Guardian Signature (when applicable) Witness