Release Authorization Form

I hereby authorize Dr. Matthew L., Smith, Psy.D.

	To send copies to: To obtain copies from:	
	To discuss pertinent information with: (Please check all that apply)	
	en completed and signed by you, authorizes the Atlanta Consulting & Psychological se or receive protected information about you or from your clinical records either to obsignate.	
I authorize Dr.	nate the appropriate authorization transaction) r. Matthew L. Smith, Psy. D., licensed psychologist, and/or his administrative and clieve (name and address of person to whom the information is to be released or receiv	
I am requesting following reaso	ng Dr. Matthew L. Smith, Psy. D., licensed psychologist, to release or receive inform sons:	ation for the
This authorizat	ation shall remain in effect 30 days or until	
my office addrereliance on the	right to revoke this authorization, in writing, at any time by sending such written not less. However, your revocation will not be effective to the extent that I have taken a e authorization, or if this authorization was obtained as a condition of obtaining insurthe insurer has a legal right to contest a claim.	ction in
psychologi psychologi	and that my psychologist generally may not condition ical services upon my signing an authorization unless the ical services are provided to me for the purpose of creat formation for a third party.	e Ling
	that information used or disclosed pursuant to the authorization may be subject to nor nt of your information and no longer protected by the HIPAA Privacy Rule.	1-disclosure
	Client or Guardian Date gal Representative	

Revised 12//05 nw/dw

*If the authorization is signed by a personal representative of the client, documentation of such representative's

authority to act for the client must be provided.