Dr. Lea Lockwood
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Wakefield, RI 02879
(401) 497-4848

AUTHORIZATION TO DISCLOSE CONFIDENTIAL HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

I, _____, hereby authorize Lea Lockwood, Ph.D, LICSW to release/disclose/obtain my confidential health information to the following specified individual or organization:

Name of Doctor or School: _____

Address: _____

Phone: _____ Fax: _____

___DO NOT RELEASE INFORMATION

The information to be used or disclosed is:

___Progress Notes ___Psychological Evaluation

___Other (specify):_____

The purpose(s) of the use or disclosure are: ___Coordination of care ___At my request

___Other (specify):_____

Specific understandings: By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is not longer protected by federal health information privacy regulations.

You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare, and your healthcare benefits will not be affected if you do not sign this form. You have a right to see and copy the information described on this authorization form in accordance with the policies of Dr. Lockwood's practice. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that Dr. Lockwood has already taken action based upon your authorization. To revoke this authorization, please write to Dr. Lockwood. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will remain valid for not more than twenty-four (24) months from the date this authorization was signed.

By :_____(patient, parent, guardian) Date:_____