Michael D. Ruch, Ph.D.

Licensed Psychologist

Phone/Fax: (616) 957-2576
2040 Raybrook Ave SE, Ste 201-C
Grand Rapids, MI 49546

AUTHORIZATION FORM

I authorize Michael D. Ruch, Ph.D. to release the following information from the record of:

_____ _____
Patient Name Date of Birth

- ❑ Psychological Evaluation Report
- ❑ Summary of Treatment and Diagnosis
- ❑ Psychotherapy Notes
- ❑ Ongoing two-way communication about my treatment
- ❑ Other _____

This information should be released to:

_____ _____

Name Address

_____ _____ _____ _____
City State Zip Fax (optional)

I am requesting the release of this information for the following purpose:

_____

This authorization shall remain in effect for one year or until this date _____

Or the following event

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____ _____
Signature of Patient (Parent /Guardian if under 18) Relationship to Patient Date

_____
Witness

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.