

# Michael D. Ruch, Ph.D.

Licensed Psychologist

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## AUTHORIZATION FORM

I authorize Michael D. Ruch, Ph.D. and/or his or her administrative staff 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
- Update of progress and diagnosis
- 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.