SUSAN FLETCHER, PH.D.
PSYCHOLOGIST • AUTHOR • FORENSICS

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I hereby authorize Susan Fletcher, Ph.D. to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit Dr. Fletcher from releasing her records regarding her treatment of me to the recipient designated below.

Recipient acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that Dr. Fletcher's release of my individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

_____ _____

Patient Name Date of Birth

Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

❑Entire Record ❑Evaluation Reports ❑Billing Records ❑Consultation Notes

❑Psychotherapy Notes ❑Other: _____

Description of the purpose of the use and/or disclosure: _____

The individually identifiable health information described herein shall be released to:

_____ _____

Name Address

_____ _____

Phone Fax

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original. **I further understand that I may revoke this authorization at any time by notifying Dr. Susan Fletcher in writing at 2301 Ohio Drive, Suite 135, Plano, Texas, 75093.** I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Name Date

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient
(attach supporting documentation)