Developmental Neuropsychology Services, PLLC
Kristy S. Hagar, Ph.D., LSSP | Licensed Psychologist
1215 Hall Johnson, Suite 100, Colleyville, TX 76034

Authorization for Release of Protected Health Information:

With your signature, this form authorizes me to release protected information from your clinical record to the person(s) you designate.

I authorize **Kristy S. Hagar, Ph.D.** to (check one or both):
_____ release the information checked below _____receive the information checked below

	Summary of Assessment and Treatment		Testing Report/Diagnostic Assessment
	Diagnostic Impressions		Verbal Exchange
	Notes of Clinical Record		Other:
	School Records/IEP		

for: _____ _____
Name **D.O.B.**

to/from:

Name:	
Address:	
Phone:	
Fax:	

For the purposes of (circle all that apply):

Treatment planning and coordination
Continuity of Care
Other: _____

This authorization shall remain in effect until one year from the date below or until _____ or unless revoked prior to expiration date via written request.

You have the right to revoke this authorization at any time by sending written notification to Dr. Hagar's 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 Dr. Hagar 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 re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of patient or parent/guardian (if patient is a minor) Date