Maureen L. Reardon, Ph.D., ABPP
Clinical and Forensic Psychologist

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME: _____
DOB: _____
SSN: _____

I, _____, hereby authorize and request **Maureen Lyons Reardon, LLC** to ___ Release information to AND/OR ___ Obtain information from

Name/Facility:	_____
Address:	_____
City, State, Zip:	_____

for the purpose(s) of:

- ☐ Continuity of Care
- ☐ Financial Reimbursement
- X Other (specify): forensic evaluation

I understand the data to be exchanged between the persons/agencies above may include a copy and/or summary of information contained in my records and/or pertaining evaluation(s) and treatment(s) received between the approximate dates of _____ and _____, specifically:

X Complete Record	☐ Discharge Summary	☐ History & Physical
☐ Consultations	☐ Progress Notes	☐ Laboratory Reports
X Psychiatric/Psychological	XOther	

I specifically authorize the release of data and information pertaining to:

X Substance Abuse _____ X Mental Health _____ ☐ HIV/AIDS _____

I understand that the current authorization for release of information is given voluntarily. I may refuse to sign. I do not need to sign this form to receive treatment. I understand that information disclosed under this authorization may be redisclosed by the recipient and, if so, may not be subject to relevant laws protecting its confidentiality. I understand that I may withdraw my consent at any time by sending a written notice to Maureen Lyons Reardon, LLC. I understand that any disclosures made by Maureen Lyons Reardon LLC prior to receipt of such written revocation shall not constitute a breach of my confidentiality rights, including those contemplated under HIPAA. This authorization shall be considered valid for no longer than is reasonably necessary to achieve the purpose(s) indicated above and will otherwise expire within 6 (six) months from the date of signature.

FAX / ELECTRONIC *** VALID ORIGINAL

_____ _____ _____ _____
Signature of Patient/Guardian Date Signature of Witness Date

Records may be delivered to Maureen Lyons Reardon, LLC

by* mail:** 13200 Strickland Rd, Suite 114-331, Raleigh, NC 27613 ***by
Fax: (919) 823-4027
***by* e-mail:** forensicpsych@reardonphd.com

Please contact (919) 800-1174 payment is required prior to fulfilling request