Marjorie Lamphear, PhD
14 Hayward Street
Cranston, RI 02910
401 837-3224

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

Regarding the Protected Health Information of _____

Date of Birth: _____

I. Marjorie Lamphear, PhD is hereby authorized to disclose to

_____

_____ the following health care information: _____

_____

II. The Information will be used for the purpose of_____

_____

III. I understand that any alcohol and/or drug treatment records are protected under the Federal Regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.

IV. This authorization may be revoked by me at any time after execution upon written request to Marjorie Lamphear, PhD. In any event this authorization will expire automatically on: _____

V. If this authorization is for the release of psychotherapy notes, I am aware that they may be subject to redisclosure, without my permission, by the individual/entity named in Section I above.

VI. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I understand that I am under no obligation to sign this authorization.

VII. I have been offered a copy of this form.

_____ _____

Patient Witness

Date Signed _____