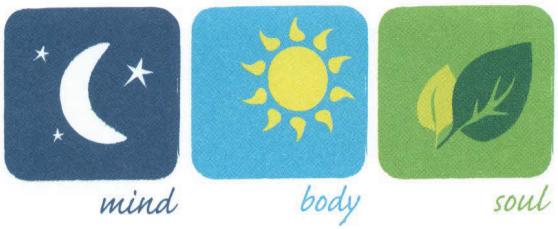

Heidi Rimer Cherwony, Psy.D., P.A.

Licensed Clinical Psychologist

Authorization to Use and Release Protected Health Information

Patient Name: DOB:

This form, when completed and signed by you, authorizes me to release or obtain protected information from your clinical record to the person you designate. You agree and understand that this form does not constitute a general release, and that by checking off or specifying information below you are agreeing to an informed release of specific sensitive and confidential information.

I am requesting the release of this information for the following reasons: (please check one)

_____At the request of the patient or authorized representative
_____For treatment care coordination

I authorize my psychologist, Dr. Heidi R. Cherwony to release or obtain the following information:

- Psychological Evaluation
- Summary of Records
- All information
- Test Results
- Other_____

This information should only be released to or obtained from:

- My physician
- My psychiatrist
- My teacher/ school
- My dietician, occupational therapist, physical therapist
- The person who referred me
- Family Member
- Other_____

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10800 N Military Trl, Suite 213, Palm Beach Gardens, FL 33410
www.mindandbodydoctor.com

Name, address, email, fax and telephone number of person to whom information is to be released:

_____
_____
_____
_____
_____

____ This authorization shall authorize for release of information from_____ to _____.

____ This authorization shall authorize for release of information from _____ until 120 days following the termination of therapy or closure of my case or file with Heidi R. Cherwony, Psy.D, P.A.

You have the right to revoke this authorization in writing at any time by sending such written notification to one of our offices. However, your revocation will not be effective to the extent that we 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.

By signing below you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

Signature of Patient or Authorized Representative

_____

Printed Name of Signer _____ Date _____

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.

ATTENTION TO AGENCIES AND/OR TO INDIVIDUALS TO WHOM THIS INFORMATION IS TO BE DISCLOSED:

If you have received this information in error please contact our office as soon as possible to arrange for the return of the received material. This information may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed by law.