Stewart R. Beasley, Jr. Ph.D., llc

1366 East 15th Street, Edmond, OK 73013

(405) 341-4313   (405)330-4567

Authorization Form

For Uses and Disclosures of Patient Health Information

Name: ______________________________ Date of Birth: ______________________________

I hereby authorize STEWART R BEASLEY JR. PH.D.

To **receive/release** the protected health information indicated below from

Name: ____

Address: ____

Phone: ______________________________ Fax ______________________________

Request Information:

I authorize the disclosure or receipt of the following types of records created from ONE-YEAR-PREVIOUS TO THIS DATE to PRESENT.

( ) Consultations
( ) Treatment Summary
( ) Diagnostic Assessments
( ) Other ______________________________
( ) Psychological Evaluations

Purpose of the Requested Use or Disclosure: The Purpose of the use or disclosure is at the request of the patient.

Expiration Date: The authorization will automatically expire one year from the date of signature below.

Patient- Please Note the following:

You may refuse to sign this authorization. Your refusal will not affect your ability to retain treatment or payment.

1. If the person or parties who are authorized to receive/release the information above are not health care providers or health plan covered by federal heath privacy laws. They may re-disclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our clinic addressed to: STEWART R BEASLEY JR., PH.D., 1366 East 15th Street, Edmond, OK 73013.
3. The information authorized for release may include reports which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS) and/or mental health information.

Signature ____ Date: ____________________

Patient or Legal Representative

Capacity of * Legal Representative (If applicable): ______________________________