WISCONSIN SCHOOL OF PROFESSIONAL PSYCHOLOGY, INC
PSYCHOLOGY CENTER
Training Institute

Authorization Form

This form, when competed and signed by you, authorizes a release of protected information from your record to the person you designate.

I authorize _____ and/or his or her administrative and clinical staff to release:

_____

_____

_____

(Provide description of the information you want disclosed. Your description should be as specific and as detailed as possible.)

This information should only be released to (name and address of person to whom the information is to be released):

_____

_____

_____

I am requesting that the individual noted above release this information for the following reasons
(Note: "at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose):

_____

_____

_____

The authorization shall remain in effect until (fill-in expiration date OR fill-in an event after which this authorization is no longer valid):

_____

_____

You have the right to revoke this authorization at any time by sending such a written notification to the office address noted at the bottom of this page. However, your revocation will not be effective to the extent that action has been taken 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 my therapist generally may not condition psychological services upon my signing an authorization unless the authorization is specified in a separate agreement (e.g. court-ordered evaluation).

I understand that information used or disclosed pursuant to authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____
Patient's Name (Please Print) Patient's Date of Birth

_____ _____
Signature of Patient/Legal Representative Date

_____
If legal representative, state relationship and authority to act for the patient

9120 W. Hampton Avenue, Suite 90-Milwaukee, WI 53225
(414) 466-WSPP