DR. NETTA SHAKED, PA
LICENSED PSYCHOLOGIST

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION AND RELEASE OF INFORMATION FORM

I_______________________________ (*print name of patient*) understand that Dr. Netta Shaked, PA is authorized by me to disclose my Protected Health Information (PHI) for purposes which include diagnosis, treatment, evaluation, consultation, gathering information, and/or other psychological services. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipients of that information. I specifically authorize Dr. Netta Shaked, PA to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be PHI. I further understand that I retain the right to revoke this authorization.

Name of recipient (include phone, fax and email) with whom Dr. Shaked may exchange information:

1. ____
2. ____

Purpose of this disclosure:

☐ To facilitate treatment and/or evaluation of myself or my family, if applicable
☐ To convey test results and evaluation recommendations
☐ Other: _______________________________________

I am aware that I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, Dr. Netta Shaked, PA must receive the revocation in writing and must include: 1. Patient's name, address, and date of birth; 2. Effective date of the authorization and the recipients authorized; 3. The patient's desire in writing, to revoke this authorization; and 4. The date of revocation and the patient's signature. All revocations must be sent to Dr. Netta Shaked, PA and are not effective until received.

This authorization shall expire: ☐ Upon completion of treatment, evaluation and/or provisions of recommendations; or ☐ Date:_____________

After the expiration, Dr. Netta Shaked, PA can no longer use or disclose my PHI without first obtaining a new authorization form. I fully understand and accept the terms of this authorization.

*Patient/Guardian Signature/Electronic Signature*___________________________________

*Printed Name*_______________________________________ *Date* _________________

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