KRUMMEL&ASSOCIATFB,P.C.

AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize DEBORAH KRUMMEL, M.A., LP.C. and/or his or her administrative and clinical staff __________________ to release and/or receive (include detailed description)

____

____

This information should only be released to and/or received from (name and address of person to whom the information is to be released or received)

____

____

I am requesting this information be released for the following reasons: ("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).

____

Disclosure may include: paper copy, verbal, fax, electronic transmission.

This information shall remain in effect until _________ or until __________

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I 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.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protect by the HIPAA Privacy Rule.

______________________	______________________
Signature	**Date**
______________________	______________________
Parent or Guardian Signature	**Date**
______________________	______________________
Witness	**Date**

9525 Katy Freeway Suite 200 Houston, Texas 77024 713-263-0400 Fax: 713-263-0333 www.krummelandassociates.com