Susan Kupferberg, JD, PhD
Druid Pointe
2751 Buford Highway
Suite 401
Atlanta, Georgia 30324
404.639.5556

Authorization For Release of Information

This form, when completed and signed by you, authorizes Dr. Kupferberg to release and to obtain protected information from your clinical record.

I, ____authorize the release and/or exchange of information about my treatment, either verbally or in writing, between Dr. Susan Kupferberg and the following party or parties:

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Purpose of disclosure:

☐ Coordination of Care ☐ Other (specify)_______________________________

This authorization shall remain in effect until termination of treatment, unless otherwise specified herein: ____(termination date if applicable)

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 my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

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

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Signature of Patient Date