Michaela Mendelsohn, Ph.D.
Licensed Psychologist
(617) 429-3523

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Cambridge, MA 02138

18 Grove Street, Suite 7
Wellesley, MA 02482

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION:

Patient's Name_____ Date of Birth _____/_____/_____

Patient's Address _____

I authorize Dr. Michaela Mendelsohn to _____ Obtain from ____ Release to _____ Mutually exchange with

Name/Facility _____

Address_____

Phone # _____ Fax # (if applicable) _____

The following information contained in my medical/psychiatric/substance abuse records pertaining to services provided on or about _____:

____ Admission Note _____ Discharge Summary _____ Physical Exam____ Treatment Plans _____ Consults

____ Psychological Testing ____ Verbal Contact Other:_____

_____

I am requesting Dr. Mendelsohn obtain/release this information for the following reasons:

_____

This authorization shall remain in effect until (expiration date) _____or until (event that relates to purpose of use or disclosure)_____

I have carefully read and understand the above statement and do herein expressly and voluntarily consent to the disclosure of information and/or psychiatric records, including alcohol and drug abuse information, if applicable, about my condition and treatment to/from those persons/ agencies names above. I agree that a copy of this form is valid as the original. I understand that I may revoke this authorization at any time. However, this revocation will not be effective to the extent that Dr. Mendelsohn has 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 the information and no longer protected by the HIPAA Privacy Rule.

Date: ____/____/____ Signature of Patient: _____

Signature of Parent/Guardian (if under 18): _____

Date: ____/____/____ Signature of Witness: _____