Portland Pain Psychology
Authorization Form

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

I authorize Portland Pain Psychology and Dr. Frederick Grossman to release the following: (Provide description of the information you want disclosed. Your description should be as specific and detailed as possible.)

_____
_____
_____

This information should be released only to: (Provide name and address of person to whom the information is to be released. If you would like documents sent via email or fax, please indicate the email address or fax number. Please note that the security of electronic transmissions via email/fax cannot be guaranteed – by indicating a fax number or email address and signing this form, you agree to accept any potential risks of such transmissions.)

_____
_____
_____

I am requesting Portland Pain Psychology to release this information for the following reasons/purpose:

_____
_____
_____

This authorization shall remain in effect until:

_____

This authorization may be revoked at any time. The only exception is when action has already been taken in accord with your authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand that generally my therapist will not make my treatment contingent 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 the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

_____ _____

Signature of Patient Date

_____

(If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.)