Chingyen Godwin, Ph.D., NCSP
Licensed Psychologist

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Littleton, CO 80120

303-794-7761 (phone)
303-794-7811 (facsimile)

Authorization Form

This form, when completed and signed by a client, authorizes Dr. Godwin to exchange protected information from the client's clinical record to the person designated.

I, _____ (print name), date of birth _____ authorizes Dr. Godwin to exchange, by releasing or obtaining, the following information:

_____

_____

_____

With the following individual/agency:

Name: _____
Address: _____

_____

Phone number: _____

My request for the exchange of information is for the following reason(s):

_____

_____

This authorization shall remain in effect until six (6) months of the date signed below or otherwise specified here: _____

I understand I have the right to revoke this authorization at any time by sending a written request to Dr. Godwin's office address. However, the revocation will not be effective to the extent that Dr. Godwin 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 Dr. Godwin generally may not make signing an authorization a condition of providing psychological services unless the psychological services are provided for the purpose of creating health information of a third party.

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

_____ _____
Signature of Client/Representative Date

_____ _____
Signature of Witness Date

IF the authorization if signed by a personal representative of the client (e.g., Parent), a description of such representative's authority to act for the client must be provided here: _____