Kari Lenox, Ph.D.

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AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

DATE:	**ACCOUNT NO.:**		
COMPLETION AND SIGNING OF THIS FORM AUTHORIZES ANY CLINICAL OR ADMINISTRATIVE STAFF OF DR. KARI LENOX, PH.D. TO RELEASE, OBTAIN, OR EXCHANGE PROTECTED HEALTH INFORMATION (PHI) FROM PERSON(S) AND/OR AGENCIES YOU DESIGNATE. I AUTHORIZE DR. LENOX TO RELEASE, EXCHANGE, AND/OR OBTAIN INFORMATION FROM THE FOLLOWING:			
PATIENT INFORMATION:			
Patient Last Name:		Patient First Name:	Birth date: / /
Age:	Gender:	Home Phone:	Cell Phone:
Street Address:		City:	State: Zip Code:
PEDIATRICIAN / PHYSICIAN			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:
PSYCHIATRIST / OTHER THERAPIST			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:
SCHOOL			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:
OTHER (ATTORNEY; AGENCIES; ETC.)			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:

I may limit this exchange of information to:_____ (list content) otherwise only information related to the coordination of care and treatment will be exchanged. This authorization is only for the limited purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I have the right to revoke authorization at any time by sending written notice to Dr. Kari Lenox. Revocation of consent will not be effective to the extent that action based on the consent has already taken place or if this authorization was obtained as a condition of obtaining health insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization is beyond the control of Dr. Lenox and consequently may be subjected to re-disclosure by the recipient and no longer protected by HIPAA. This authorization will expire in 365 days unless I elect an expiration date of: ___/___/___

Signature:	Witness:	Date: