Lisa Strohman JD, PhD
8757 East Bell Road
Scottsdale, AZ 85260
480.650.1720

Authorization Form

This form when completed and signed by you, authorizes me to obtain protected information from and / or release protected information to the person you designate.

I authorize my psychologist, Dr. Lisa Strohman and her administrative staff to release / obtain:
____ My entire record
____ A summary of my treatment
____ Information via verbal contact

This information should only be released to / obtained from:
_____

_____

_____

I am requesting my psychologist to release / obtain this information for the following reasons:
____ At my request
____ Other: _____

This authorization shall remain in effect until _____ or until termination of treatment with Dr.Strohman.

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 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 Minor, Legal Guardian Date