Max Taylor, Psy.D, LLC
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Release of Information

General Consent for Use or Discloser of Protected Health Information

Consent for Release of Information about: _____ **DOB:** _____

_____ hereby authorizes the release of my protected health information by
Client Name/Legal Guardian/Organization

_____Max Taylor, Psy.D._____
Therapist

AND

Name of Person/Organization Receiving Information: _____

Address: _____

City/State/Zip: _____ **Phone**: _____

Information to be Released or Obtained:

Diagnosis, Dates of Service: ☐
Progress/Treatment Notes: ☐
Billing Records: ☐
Medical Records: ☐
Info. not to be Disclosed: _____

Academic Records: ☐
Test Scores and Evaluation Results: ☐
Other (please specify): _____

Purpose of this Authorization:

Treatment Provider Communication: ☐
Insurance Authorization and Billing: ☐
Legal matter (court/attorney request, testimony, etc.): ☐
Assessment Diagnosis and Planning: ☐

Facilitate evaluation or treatment: ☐
Other (please specify): _____
At your Request (no purpose given): ☐

Exchange of Information may be Transmitted:

Verbal Exchange: ☐ Electronic Exchange: ☐ Written Exchange: ☐

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of _____ (Insert Date) or the date my coverage ends with _____.

I understand that I have a right to revoke this authorization at any time by providing written notice to Dr. Max Taylor, Psy.D. . However, this authorization may not be revoked if _____, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility coverage of services.

_____ _____

(Printed Name) (Date)

_____ _____

(Signature of Client) (Date)

_____ _____

(Printed Name of Legal Guardian if Client is a Minor) (Date)

_____ _____

(Signature of Legal Guardian if Client is a Minor) (Date)

Revised 04/2019