Diane Hediger, Ph.D.
Licensed Psychologist
4736 Royal Ave. #17179
Eugene, OR 97402
(541) 556-8332
www.dianehedigerphd.com

Authorization Form

I_____, Date of Birth_____
(name of client)
authorize, Diane Hediger, Ph.D. to (*check one or both boxes)*

- **DISCLOSE** my personal and protected health and mental health information to:

AND/OR

- **OBTAIN** my personal and protected health and mental health information from:

_____
(provide name/address/telephone number of person to whom the information is to be released)

By *initialing* the spaces below, I specifically authorize the disclosure of the following health records:

___ Diagnosis, symptoms & functional status
___ Treatment Summary
___ Medical records needed for continuity of care
___ Medication prescriptions and monitoring
___ All hospital records
___ Discharge Summary
___ Treatment plan, prognosis, and progress
___ Attendance/scheduling
___ Results of clinical and psychological testing
___ Emergency and urgency care records
___ Payment records and billing statements
___ Other (specify):

I am requesting that Diane Hediger, Ph. D. discloses/obtains this information for the following reason(s):

_____ Coordination/Continuity of care
_____ At the request of the individual
_____ Other (specify):_____

Your rights: Your signature on this Authorization cannot be required to receive your health care and payment for that health care, unless the health treatment is for the purpose of: (1) Creating health information about you to be disclosed to a third party; or (2) For the purpose of research.
You have the right not to sign this Authorization. You have the right to revoke this Authorization at any time. If you revoke your Authorization, we will no longer use or disclose the above information about you, but we cannot take back any disclosures already made with your permission. To revoke this Authorization, please send a written statement to Diane Hediger, Ph. D. (at PO Box 5243, Eugene, OR 97405), that identifies the date of this Authorization and the recipient of the information listed in this Authorization, and state that you are revoking this Authorization. This Authorization will expire on the earlier of either termination of services or at the following other event:

I have reviewed and I understand this Authorization. By signing this Authorization, I am directing my health care provider to disclose my health information to another person or organization that may not have to obey the same obligations to protect privacy under state and federal law. Therefore, **the disclosure of the information specified above carries with it the potential for unauthorized redisclosure** and loss of protection under state and federal law.

By_____ Date:_____
(patient)
By_____ Date:_____
(patient representative)
Description of Representatives Authority:_____