Nusha Askari, PhD, PSY31589
HIPAA Authorization Form

Written Consent for Disclosure of Client Health Records (Page 1 of 2)

Please note that the completion of this form constitutes written authorization to release client health records held by Nusha LLC/ Dr. Nusha Askari. Nusha LLC/ Dr. Askari shall not condition treatment or payment based on this authorization. Client may refuse to sign this authorization. If the authorization is not signed, the information shall not be released except when required by law.

Client Full Name (Print): ____

Client Date of Birth: ____

Name of Client's Parents/Legal Guardian/Conservator (if applicable; Please Print):

____

Client Street Address: ____
City, State, Zip Code: ____

I,______________________________, and/or ______________________________
(Name of Client) (Name of Parent/Legal Guardian/Rep)

hereby authorize Nusha LLC/ Dr. Nusha Askari to exchange the following specified information of my health records:

______**Request records to be released to Nusha LLC/ Dr. Nusha Askari**
Name of Person/Agency/Organization: ______________________________
Phone Number ______________________________
Fax Number ______________________________
Address______________________________
Relationship to Client ______________________________

______**Release record to the following facility:**
Name of Person/Agency/Organization: ______________________________
Phone Number ______________________________
Fax Number ______________________________
Address______________________________
Relationship to Client ______________________________

I understand this authorization contains the knowledge that such release discloses the fact that mental health services have been/are being provided.

This disclosure of information is required for the following purpose(s):
______Evaluation
______Treatment Planning
______Other (please specify) ______________________________

Written Consent for Disclosure of Client Health Records (Page 2 of 2)

This authorization becomes effective as of (Month/Date/Year)______________________________.
I understand that I may revoke/cancel this authorization by notifying Nusha LLC/ Dr. Nusha Askari in writing by the undersigned at any time except if that action has already been taken. If not revoked, this authorization shall terminate at the end of
_______Six Months _______One Year _______Other Date (Please specify:______________)

I understand that I am to receive a copy of this authorization. Print name below:

____ ____________________

Client Signature__________________________________ Date ___________________

____ Date ___________________
Parent, Guardian, or Authorized Representative Signature

____ Date ___________________
Nusha LLC Staff / Dr. Nusha Askari Signature

Record of Release of Information (To Be Completed After Release):

The following information of ____

____

____

____was

Received from ____

Released to ____

On (Month/Date/Year) ____