The MINDset Center
Authorization Form for Dr. Hessler

This form, when completed and signed by me, _____ (client's name), authorizes the release of protected health/educational information (PHI) from my clinical record to the person(s) I designate. I authorize my therapist, Dr. Shreya Hessler, to release:

_____
_____(provide specific and detailed description of the information requested for disclosure).

This information should only be released to:
Name: Agency:
Address:
Telephone:
I am requesting that Dr. Shreya Hessler release this information for the following reasons:
_____("at the request of the individual" is all that is required).

This authorization shall remain in effect until: _____
(fill in expiration date or event that relates to the individual or the purpose of the use or disclosure. Note: date may not exceed one year).

I understand that Dr. Hessler cannot re-disclose information she received from another health care provider if that health care provider requested that the information not be re-disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

I have the right to revoke this authorization at any time by sending written notification to Dr. Hessler. However, my revocation will not be effective to the extent that she has 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 therapist 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.

_____ _____
Signature of client Date

_____ _____
Signature of parent or legal guardian Date
Relationship to client:

__Shreya Patel Hessler, Psy.D., LLC_____
Electronic Signature of witness (therapist)