Release of Information Authorization Form

Pamela G. Luttig, PhD

Licensed Psychologist

This form, when completed and signed by you, authorizes Pamela G. Luttig, PhD to secure and/or release protected information from your (or your minor child's) clinical record to and from the person(s) you designate below.

I, _____(your name), authorize Pamela G. Luttig, PhD and/or or her staff to secure and release information related to the treatment of myself and/or my minor child_____(child's name), including any treatment and/or evaluation information and test results to the following:

1._____ _____
Pediatrician or Internist Name Phone Number

2._____
Psychiatrist Name Phone Number

3._____
Other Phone Number

I am authorizing Pamela G. Luttig, PhD to secure and/or release this information at my request. I understand that I have the right to revoke this authorization, in writing, at any time by sending such notification to Pamela G. Luttig, PhD's office address. However, this revocation will not be effective to the extent that Dr. Luttig has acted in reliance on this 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 the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by HIPAA Privacy Rules.

_____ _____
Signature of Patient (or legal guardian) Date

_____ _____
Signature of Patient (or legal guardian) Date