Jonathan S. Abramowitz, PhD, ABPP

Authorization Form

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Name ____ DOB ___________

This form when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

I authorize the exchange of information between Jonathan Abramowitz, PhD and the following:

1. Referring care provider
   Name____ Phone____________________________
   Address____
   City_____________________________________ State______________ Zip_____________________

2. Other
   Name____ Phone____________________________
   Address____
   City_____________________________________ State______________ Zip_____________________

3. Other
   Name____ Phone____________________________
   Address____
   City_____________________________________ State______________ Zip_____________________

Information to be released includes: ____
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This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged confidential information.

I am requesting this information exchange for the purpose of ______________________________

This authorization will remain in effect for 2 years unless you designate a time period below. You may revoke this authorization at any time by providing written notice to Dr. Abramowitz.

Expiration if different from above: _____________________________________

This authorization is fully understood and voluntarily made on my part.

___________________________________		____
Patient's signature	OR	Parent/Legally appointed representative's signature
___________________________________		____
Date of signature		Relationship if not parent

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