Psychological Sunrise Center, PLLC
Dr. Dina Reimer, Psy.D.
Licensed Clinical Psychologist
www.psychologicalsunrisecenter.com
(480) 563-3587

Authorization for Mutual Exchange of Protected Health Information

Client Name: _______________________________ D.O.B.: _____/_____/_____

This form when completed and signed by you authorizes Dr. Dina Reimer to release/request protected health information from your clinical record to/from the person/agency you designate.

I, ____, request that Dr. Dina Reimer, Psy.D. release/request the information
(Client/Parent/Legal Guardian Name)

specified below regarding my / my child's / my ward's treatment to/from:

____
(Name, Phone, Fax, Email of Person/Agency to **receive/release** information)

for the purpose of treatment coordination. This consent begins on _____/_____/_____ and ends upon termination of treatment. I choose to release the following information specifically:

Verbal content associated with progress in treatment	Written content associated with progress in treatment	Other:	Other:

(Circle to indicate information to be released and/or write in additions)

The following methods are approved for a mutual exchange of information (circle): Telephone Email Written Fax

I choose to withhold the following information:

____

____

I understand that this consent to release information is revocable in part or in whole at any time upon written request, except to the extent that Dr. Reimer has taken action in reliance on the authorization.

I HAVE BEEN PART OF DEVELOPING THIS CONSENT: ____ ______________
CLIENT/PARENT/LEGAL GUARDIAN SIGNATURE DATE

____ ______________
CLIENT/PARENT/LEGAL GUARDIAN SIGNATURE DATE

PSYCHOLOGIST'S SIGNATURE: ____ ______________
NAME/DEGREE/LICENSE # DATE