Linda Olson, Psy.D.

5605 Glenridge Drive · One Premier Plaza, Suite 600 · Atlanta, GA 30342 · Ofc: 770.756.7013 Fax: 404.257.0299

www.drlindaolson.com

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, _____

(print your name)

(Date of Birth ___/___/____), hereby authorize **Linda Olson, Psy.D.** to (release/obtain) my medical records that are protected under HIPAA guidelines. I understand that by signing this authorization I am waiving my privilege in its entirety.

For the Purpose of:

- € Coordination of Care
- € Treatment Plan/Continuing Care Recommendation
- € Other:_____

To/From:

Doctor's Name or Facility: _____

Address: _____

_____

Phone:_____ Fax: _____

I authorize **Linda Olson, Psy.D.** and/or members of her staff to furnish information to the above named person, organization or its agents, and that I further agree to indemnify and hold harmless **Linda Olson, Psy.D.** and her staff from all liability that may arise from the release of the information herein requested. Any information obtained from this authorization should not be re-released to any other persons unless I specifically authorize it to be. However, once the information is released as I am requesting, I understand that neither **Linda Olson, Psy.D.**, nor her staff, have any control over the further management of the records so released.

I understand that the records released may contain alcohol and drug treatment information, as well as psychological information. I understand that treatment is not conditioned on my signing this form.

I understand that I may revoke this consent at any time, except to the extent that action has already been taken, and by giving written notice to the Records Department of this facility.

_____ _____

Signature of Patient Date

_____ _____

Parent or Guardian (if applicable) Date

_____ _____

Signature of Patient to Revoke Release Date Ended/Date Revoked