AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize James A. Fidelibus, Ph.D. to disclose my Protected Health Information to:

_____

under the following specified conditions:

1. This authorization pertains to disclosure of only the following elements of PHI:
   - ( ) Name, age, date of birth
   - ( ) Social Security Number
   - ( ) Clinical evaluations, testing
   - ( ) Treatment goals
   - ( ) Dates of service
   - ( ) Other:
   - ( ) Residence, phone
   - ( ) Place of employment, phone
   - ( ) Diagnosis, clinical formulation
   - ( ) Methods, service codes
   - ( ) Treatment progress, completion

2. This disclosure is intended for the following use/s:
   - ( ) Coordination of care
   - ( ) Verification of attendance/participation
   - ( ) Other:
   - ( ) Verification of progress
   - ( ) Professional consultation

I understand that James A. Fidelibus, Ph.D. cannot be held responsible for the redisclosure of this information by the person/s or class of person/s receiving it, or by any actions taken as a result of this disclosure.

I understand that I can revoke this authorization by notifying James A. Fidelibus, Ph.D. in writing of my desire to revoke it. I also understand that if I revoke this authorization, it will have no effect on any actions taken in reliance upon it by James A. Fidelibus, Ph.D. prior to the revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that this authorization will expire as follows:

( ) On the following specified date:

( ) On the happening of the following event that relates to the purpose of this use or disclosure:

_____

My signature below also verifies this form was fully completed before signing.

_____ **X** _____

Witness — Patient or Personal Representative

_____ _____

Date of Signature — Patient's Name

_____

Patient's Address

_____

Name of Personal Representative

_____

Representative's Authority to Act