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This form, when completed and signed by you, authorizes Dr. Taylor to release protected information from your clinical record to the person(s) or entity(s) you designate and to obtain protected information from the person(s) or entity(s) you designate.

Patient/Client Name: _____
Date of Birth: _____

I authorize Dr. Taylor's office to release records or information OR to obtain records or information regarding the above named person. These records may include any medical records, academic records, psychological or neuropsychological evaluations, treatment notes, diagnosis, recommendations, or any other information that is related to my care.

I authorize my records and information to be released to or obtained from the following individuals/entities:

Full Name: _____	Phone: _____
Address: _____	Fax: _____
Full Name: _____	Phone: _____
Address: _____	Fax: _____
Full Name: _____	Phone: _____
Address: _____	Fax: _____
Full Name: _____	Phone: _____
Address: _____	Fax: _____
Full Name: _____	Phone: _____
Address: _____	Fax: _____

This authorization shall remain in effect for one year from the date of signing or until I revoke this authorization, in writing, at any time by sending such written notification to the office address. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient or Guardian Date

If signed by a guardian, please state legal basis for guardian status: _____