

**Elaine S. Berman, Ed.D.**  
**Psychologist**  
**1712 Lago Vista Boulevard**  
**Palm Harbor, FL 34685**  
**(727) 784-8392 (Tel); (727) 771-2796 (Fax)**

**AUTHORIZATION FORM**

I authorize \_\_\_\_\_ to release to my psychologist, Elaine S. Berman, Ed.D. the following information (Your description should be as specific and detailed as possible).

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I am requesting this information be released for the following reasons (at the request of the individual is all that is required if you are my patient and do not desire to state a specific purpose).

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This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

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You have the right to revoke this authorization in writing, at any time by sending such written notification to the party releasing the information.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

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Signature of Patient or Parent or Guardian

Date

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(Please Print Patient's Name and Date of Birth)

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.