BRYN DUNGAN, PSYD, HSPP
Clinical Psychologist

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AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this authorization, I authorize exchange of information for the following purpose (check all that apply):

	Attendance in Treatment		Discharge Summary		Psychological Evaluation
	Progress in Treatment		Treatment Plan		Other:
	Prognosis/Diagnosis		Progress Notes		

Between the following organization or person and Dr. Bryn Dungan, PsyD, HSPP:

Name/Organization: ______________________________

Phone Number: ______________________ Fax: ______________________

Address: ______________________________

City, State, Zip: ______________________________

____

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

I understand that when the information is used or disclosed related to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that I have the right to revoke this authorization at any time in writing, excluding any information Dr. Dungan has already released based upon this authorization. I understand this authorization will expire in **1 year** or when the patient turns **18 years old**, whichever comes first.

____
Signature of Patient/Parent/Guardian

____
Witness Signature

____
Printed Name of Patient/Parent/Guardian

____
Printed Name of Witness

____
Relationship to Patient

____
Date Witnessed

____
Date Signed