Steven Korner, Ph.D.
Licensed Psychologist #1584/Certified School Psychologist

135 County Road
Cresskill, New Jersey 07626
(201) 894-8881

Authorization Form

This form when completed and signed by you, authorizes me to
__ _obtain information
__ _ release protected information from your clinical record to the person you designate.

I authorize my psychologist, Steven Korner, Ph.D., to obtain and release information to
_____
_____
_____

This information should only be obtained from/released to (name and address of person)
_____
___

I am requesting my psychologist to obtain/release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.) To understand current academic struggles

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).
Until work together is completed

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I am aware of my right to confidential communications under psychologist-patient privilege. (This sentence is only required for authorizations under the New Jersey Peer Review law).

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

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.

_____ _____

Signature of Patient (after age 14)/Parent Date

_____

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