HALLETT PSYCHOLOGICAL SERVICES, LLC

11350 NORTH MERIDIAN STREET, SUITE 300
CARMEL, IN 46032
317-660-1221
317-660-6223 FAX

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the patient (or legal guardian of the patient), authorize Lindsay Hallett, PsyD, HSPP to exchange information with:

Name: _____

Address: _____

_____

Phone: (_____) _____-_____

Fax: (_____) _____-_____

Email: _____

for the purpose of the evaluation, treatment, or psychological consultation regarding _____ (patient's name), ____/____/____ (date of birth). This permission includes oral communication and relevant patient information, including but not limited to, diagnoses, copies of records, and summaries of treatment.

I understand that when the information is 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. Hallett has already released based upon this authorization.

I understand that this authorization will expire in **1 year** or when the patient turns **18 years old**, whichever comes first.

A copy of this release shall have the same force and effect as the original.

_____ _____

Patient (or legal guardian's) signature- 18 years of age or older Date

_____

Patient (or legal guardian's) printed name

_____ _____

Lindsay Hallett (Zimmerman), PsyD, HSPP Date