Joel I. Kimmel, Ph.D., P.A. & Associates

• Clinical Psychology • Marriage and Family Counseling • Corporate Psychology

5551 N. University Drive, Suite 102
Coral Springs, Florida 33067
Tel: (954) 755-2885
Fax: (954) 344-6007
www.KimmelPsychology.com

**AUTHORIZATION WHEN PATIENT REQUESTS USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorize Joel I Kimmel, Ph.D. P.A. and Associates to disclose the following information: (Describe the protected health information to be used or disclosed in a specific, meaningful fashion)

________________________________________________________

________________________________________________________

To: (Identify by name and address the person/entity to whom disclosure is being made to or who will be using the information.)

________________________________________________________

________________________________________________________

________________________________________________________

**This authorization will expire on: _____________________________________**

I understand I have a right to revoke this authorization ***in writing*** except to the extent that Joel I. Kimmel, Ph.D. P.A. and Associates has taken action or has relied on the authorization. This authorization may be revoked by my requesting in writing and delivering a copy of the same to my provider.

One the uses and disclosures have been made pursuant to this authorization, they may be subject to redisclosure by any recipient and no longer protected by federal privacy laws.

Joel I. Kimmel, Ph.D. P.A. and Associates will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for disclosure of the protected health information to such third party.

Signature: ________________________________________

Date: __________________________

Signature of Personal Representative of
Patient: __________________________________________

Description of Representative's Authority to Act on behalf of
Patient: __________________________________________