William Ballantyne, Psy.D.
Licensed Psychologist VT & NH
Office Location: "The Mill" - Maxham Meadow Way Woodstock VT 05091
Mailing Address: 2 Runnemede Lane Windsor VT 05089
Telephone: (802) 296-1211

Authorization to Disclose/Obtain Protected Health Information

Client Name (print): ____
Date of Birth: ______________

This authorization relates to communication/sharing of information between Dr. Ballantyne and the following person(s) or entity:

Name of person(s) or entity: _____________________________________

Street address: ____ City: ____________ State: ___ Zip: ____ Tel: ____

I authorize the use/disclosure of the following information:

____

____

____

By signing this document, I understand the following:

1. That this authorization is valid for the purposes stated above. A photocopy shall be considered effective and valid.
2. That this authorization may be revoked in writing and delivered to Dr. Ballantyne at any time, although the revocation will not be effective to previously disclosed protected health information pursuant to a valid authorization.
3. That if I authorize disclosure of protected health information, the recipient may further disclose this information, and it may no longer be protected by federal and state law.

I authorize Dr. William Ballantyne to DISCLOSE my protected health information to the above named persons(s)/entity:

____
Signature of Client or Representative Date

For the following purposes:____

I authorize Dr. William Ballantyne to OBTAIN my protected health information from the above named persons(s)/entity:

____
Signature of Client or Representative Date

For the following purposes:____

Authority or relationship of representative: ____________________

Expiration date: This authorization will expire no later than one year from the date this form was signed.