Patient Authorization for Disclosure of PHI
(Personal Health Information) for Psychological Testing Services

As a way to provide excellent care to our clients, Thrive Counseling offers psychological and personality testing services, provided by clinical psychologist Dr. ********. To receive a consultation from Dr. ******, simply supply the requested contact information, and grant your therapist permission to communicate about what testing services will be most helpful to you.

Client name: ____

Best phone number to be reached: ____

Best time of day to be reached: ____

Special requests: ____

By signing, I authorize **Thrive Counseling LLC** to disclose protected health information (PHI) about me to Dr. ****** and administration of ******* Associates, for the purposes of helping me arrange an appointment for psychological testing services. I understand that discussion may involve aspects of my counseling treatment.

I have the right to refuse to sign this authorization, and I maintain the right to retract this authorization at any time.

Signed by: ______________________________ ______________________
Signature of Patient (or Legal Guardian) Date