DR. WANDA EPPES & ASSOCIATES
LICENSED PSYCHOLOGIST ♥ SCHOOL PSYCHOLOGIST
FL PY 4960 # FL SS 178
CO 2563 # CO 0324245

Authorization for Use or Disclosure of Information

I, _____, hereby authorize: Dr. Wanda Eppes & Associates
5458 Lake Howell Road, Winter Park, FL 32792
Phone: 407-677-4001; FAX: 888-366-4008
Email: info@DoctorWandaEppes.com

To: (check all which apply)
_____use the following protected health information, and/or _____disclose the following protected health information to, and/or _____receive the following protected health information from:

Name_____Phone_____FAX_____
Address_____City/State/Zip_____

The information released about (patient's name)_____DOB:_____ will include information which originated in the office of **Dr. Wanda Eppes & Associates** and/or the above named entity and may include: (check as many as apply)

_____medical records
_____educational records
_____computer printouts
_____behavioral observations
_____psychological evaluation or report
_____psycho-social history
_____educational recommendations
_____report cards, achievement test results

_____I request that the information be released in written form
_____I request that the above parties communicate by phone, FAX or email

This protected health information is being disclosed for: (check as many as apply)
_____MEDICAL _____EDUCATIONAL _____COUNSELING PURPOSES _____OTHER
List specific purposes here:_____

This authorization shall be in force and effect until _____at which time this authorization to use or disclose this protected health information expires. This cannot exceed one calendar year.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Lewis Jones, Privacy Contact, or Dr. Wanda Eppes, at 5458 Lake Howell Road, Winter Park, FL 32792. I understand that a revocation is not effective to the extent that **Dr. Wanda Eppes & Associates** has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Dr. Wanda Eppes & Associates will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. I understand that I have the right to:
(check)_____Inspect or copy the protected health information to be used or disclosed as permitted under federal law
(check)_____Refuse to sign this authorization

_____ _____
Signature of Patient/Parent/Guardian or Personal Representative Date

_____
Printed Name of Patient/Parent/Guardian or Personal Representative Description of Personal Representative's Authority

The office of Dr. Wanda Eppes & Associates is HIPAA compliant as of 04-14-2003