John H. Neal, Ph.D.
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Authorization to Disclose and/or Exchange Personal Health Information

Current Date: ____/_____/_____
Expiration Date: ____/_____/_____

This document constitutes permission for John H Neal, PhD to release Personal Health Information (PHI).

Persons and/or Institution authorized to receive Personal Health Information from Dr Neal:

Name: _____

Address: _____

_____

Telephone: _____

I understand that this authorization is effective immediately and will remain in effect ONLY until the expiration date specified above (no longer than one year from the date of this authorization).

I also reserve the right to withdraw or revoke this authorization, in writing at any time, except to the extent that John H. Neal has already disclosed the information to those persons and/or institutions specified above.

Client Identification: (List all that are applicable)

Client Name: _____ Date of Birth: _____

Mailing Address: _____ _____

_____ _____

Please Specify What Health Information is to be Accessed or Disclosed:

Client Signature(s):

(1)_____ (2)_____

I understand that I may refuse to sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected. I understand that I have a right to receive a copy of this authorization. If you wish to have a copy of this authorization please request a copy from Dr. Neal and he will provide one as soon as is possible.