Floyd Covey, D.D.; Th. D.; Ph. D.; C. Carm. of C.T.P.; O.SS.T.
Bishop / Priest / Psychologist / Monk
Counseling from a Christian View
Soul Care and Wisdom Guidance

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form, when completed and signed by you, authorizes me to release PROTECTED HEALTH INFORMATION from your clinical record to the person whom you designate.

I authorize my psychologist, Floyd Covey, Ph. D., and/or his administrative staff to release the following information: **Psychological Information/ Medical Records.**

The above information is to be released to: _____

_____

_____

This authorization shall remain in effect for one year from the date of the signature, or until this specific date: _____.

At any time, you have the right to revoke this authorization, only in writing, by sending such a written notification to the following address: Floyd Covey, Ph. D., P.O. Box 69, and Collierville, TN 38027-0069. However, your revocation will not be effective to the extent that I have taken action in reliance upon your authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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 the HIPAA Privacy Rule.

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Name of Patient: _____

Signature of Patient: _____ Date: _____

Name of Guardian (If Patient is a Minor): _____

Relationship of Guardian to Patient: _____

Signature of Guardian: _____ Date: _____

(rev. 2023)