# John H. Neal, PhD

Licensed Psychologist

(Inactive Status: Retired)

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## Please complete this form and FAX it to 831-457-8540
## Authorization to Disclose and/or Exchange Personal Health Information
## Questions: Email me at johnhnealphd@gmail.com

Current Date: ____/_____/_____
Expiration Date: ____/_____/_____ (no longer than 1 year from current date)

This document constitutes permission for John H Neal, PhD and the Mental Health Professional identified below to exchange Personal Health Information (PHI) for the purpose of collaboration around diagnosis and/or treatment.

### Person/Institution authorized to exchange Personal Health Information with Dr Neal:

Name:

Telephone: FAX:

Address:

Email:

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:

Residence Address:

### Health Information to be Accessed or Disclosed: (Please Specify)

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.