Roxanna W. Wolfe, PsyD
7988 Old Georgetown Rd., 8~A
Bethesda, MD 20814

Authorization Form

This form when completed and signed by you, authorizes Dr. Wolfe to access and to share protected health information about you, including your appointments, medications, and clinical record. Importantly, it allows communication and sharing information.

I, , authorize my psychologist, Roxanna Wolfe, to release / exchange information about my care and treatment, including about my appointments, medications, and planning to:

_____

I am requesting the release of this information so that Dr. Wolfe & _____ may communicate about my status & treatment.

I understand that I have the right to cancel this authorization, in writing, at any time by writing to Dr. Wolfe. However, my cancellation will not affect any uses or disclosures made prior to my cancellation or to the extent that action has been taken in reliance upon this authorization.

I understand that I am not required to sign this authorization in order to receive medical care or to pay for that care. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by federal law. This authorization shall remain in effect for one year following the date of my signature below.

Electronic Signature - Please type your first and last name:

I understand that this electronic signature constitutes a legal signature confirming that I acknowledge and agree to the above Payment Policy.

_____ _____

Signature Date