Kevin M. Harrington, Ph.D.
Licensed Psychologist
Riverview Office Tower, Suite 1490
8009 34th Avenue South
Bloomington, Minnesota 55425
612-766-9255 - 952-854-5062 FAX

CONSENT FOR THE RELEASE OF PRIVATE INFORMATION

I, _____ DOB:_____
(Print name of client giving consent)
hereby request **KEVIN M HARRINGTON, Ph.D. PA** to disclose to or exchange my

private information with:_____
(*Full name of person or organization and phone number)*

___ Telephone Consultation, without restriction to consent

___ Psychotherapy Notes

___Intake, Diagnoses, Treatment, Plan, Testing Results, Contacts

___ Other (specify below

_____

The person or organization receiving this information will use it for the following purposes:

_____

_____

I understand that I may revoke this authorization in writing by notifying Dr. Harrington at his office address, and that, in any event, this consent expires within one year of this date. However, my revocation will not be effective to the extent that he has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage or fulfilling the purpose stated above. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and not longer protected by the HIPAA Privacy Rule.

I understand that my psychologist generally may not condition psychological services upon by my signing an authorization unless the psychologist services are provided to me for the purpose of creating health information for a third party.

Executed this _____ day of _____, 20_____.

_____ _____
Signature of Client Witness

(If minor or incompetent, signature of parent or guardian)