Muriel S. McClellan, Ph.D.

Psychologist
8124 E. Cactus Road, Suite 410
Scottsdale, Arizona 85260-5262
602-956-6009
muriel.mcclellan@gmail.com

Consent for Disclosure of Protected Health Information

I hereby authorize Dr. Muriel S. McClellan (x) to release information to:
(x) to receive information from:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Pertaining to:

Client: _____

Address: _____

_____

Date of Birth: _____

It is my understanding that when this form is completed and signed, it authorizes Dr. McClellan to release and/or receive information from the person stated above. This consent to release and/or receive information can include the following:

(x) Treatment Summary	(x) Phone Conferences&Email Communication
(x) Treatment Plan	(x) History, Background Information
(x) Progress Notes	( ) Letters and other correspondence
( ) Diagnosis	( ) Reports
( ) Psychological Testing Results	( ) Other _____

I understand that the intention is to use this information to help with the co-ordination of services Dr. McClellan is providing with the above named person.

I have read the above and fully understand its contents. This consent is good for one year from the date signed, but can be revoked in writing to Dr. McClellan at any time, except to the extent that action has already been taken. I understand that after information is disclosed it may not be protected by the federal privacy rule and could possibly be released to someone else. Generally you are not required to sign this consent and if you do not sign this it will not effect your treatment unless it is Court ordered. You can review your specific Court orders for guidance. If this is Court ordered and a report to the Court is required, the information released may be included in a Court record with publc access. All efforts will be extended to handle this in a professional manner. A photo copy of this authorization will serve as valid as the original.

Name of Client (please print) _____

Signature: _____ Date: _____
Client