Daniel Noll, Ph.D.
NJ Licensed Psychologist #5410
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Authorization to Use, Disclose, or Receive Protected Health Information

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1. I am completing this form to allow the use and sharing of protected health information about:

   Printed Name: ____Date of Birth: ________________________

   Address:____
2. I authorize ***Daniel Noll, Ph.D.*** to use, disclose, or receive the following information:
   - ☐ Complete copy of treatment records, including dates of attendance, problem history, diagnoses, prognoses, level of functioning, treatment plans and recommendations, progress notes, and other written information related to treatment.
   - ☐ Treatment summary only (dates of attendance, diagnosis, prognosis, and level of functioning).
   - ☐ Psychological evaluations, reports, or assessment results, and dates.
   - ☐ Pertinent medical history and most recent office visit notes.
   - ☐ Other:____
3. To/From this person or organization:

   Name:____

   Address:____

   Phone/Fax:____
4. The information will be used/disclosed/received for the following purposes:
   - ☐ Coordination of treatment with other providers.
   - ☐ Mental health evaluation and monitoring.
   - ☐ Billing/Insurance.
   - ☐ Other:____
5. I understand and agree that this Authorization will be valid and in effect until one month after the end of treatment with Dr. Noll or other date or event upon which this Authorization expires: ______________________
6. I understand that **I can revoke or cancel this authorization** at any time by sending a letter to Dr. Noll. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent and shared before that date.
7. I understand that **I do not have to sign this Authorization** and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Noll, nor will it affect my eligibility for benefits.
8. I understand that if the person or organization that receives the released information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
9. I affirm that everything in this form that was not clear to me has been explained, and I now understand all of it.
10. I acknowledge that I may inspect and have a copy of any written health information described in this Authorization.

~Signatures~

Any Client over 14 years: ______________________________ Parent/Guardian: ____________________________ Date: _________________

~Print Names~

Client: _____________________________ Parent/Guardian: ____________________________ Relationship to Client: ____________________

11. I, a mental health professional, have discussed the issues above with the client and/or his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Professional: ____ Printed Name: Daniel Noll, Ph.D. Date: _________________
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