Robert S. Maris, Ph.D., P.A.

Clinical Psychology
#7 Office Park Drive, Suite 120
Little Rock, AR. 72211
501-219-2419

Today's date: _____

To Whom It May Concern:

I, _____understand that HIPPA prohibits discussion of my medical care with any party, including my immediate family and spouse, without specific written authorization from me.

I am granting permission for the office of Robert S. Maris, Ph.D., P.A. to speak with the following people:

1.) _____

2.) _____

3.) _____

4.) _____

I, _____do not want any discussion of my medical care with anyone. I am not releasing the office of Robert S. Maris, Ph.D., P.A. to discuss my care.

I have received the HIPPA information and policy for this office.

_____

Signature of Patient

_____

Witness