Christina Rogers | Behavioral Therapy
PEDIATRIC BEHAVIORAL SPECIALIST
2900 BEE CAVES RD STE 110 AUSTIN, TX 78746
CROGERS@CHILDBEHAVIORALTHERAPY.COM

Welcome to my practice. This document provides you with important information about my professional services and business practices.
It describes the ground rules under which I can work with you and your child effectively, ethically, and legally. I am also furnishing you a Notice of Privacy Practices, which explains your privacy rights as a patient in detail. Please read these documents carefully, and know that we can discuss any questions that you have about them at any time.
After reviewing this information, please sign the form to Consent to Treatment. Your consent serves as an agreement between us to accept these rules as the basis of our working relationship and that also authorizes you to relay any information that I must keep in my files. You may revoke this consent in writing at any time.

PSYCHOLOGICAL SERVICES I provide long-term and short-term Psychotherapy for children and Behavior Management for families. Many of the more specific aspects of my services, such as treatment methods, you and/or your child's role as the client, and duration of services, will be discussed with you individually. In general, I take a team approach in which we work together to identify and work toward goals that address the problems your child and your family are facing. Most often, you, along with your child or adolescent, will decide on the duration of therapy.
Psychotherapy can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you or your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, and helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, improved coping skills, and significant reductions in feelings of distress. But there are no guarantees of what you will experience or what the results will be. Progress depends on many factors including motivation, effort, and life circumstances.
By the end of the first session I will be able to offer you some first impressions on what our work together will include. Therapy often involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my methods, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

PROFESSIONAL FEES The initial 60 minute intake session with the primary caregivers is billed at a rate of $150 and the initial 60 minute intake session with the child is $150. Most pediatric sessions are typically 45 minutes in length and are billed at $130. 60 minute Individual or Behavior Management sessions are $150. The excess portions of sessions that extend beyond 60 minutes will be charged in 15 minute increments.
Telephone conversations with a duration of over 5 minutes, and consultation with other professionals, are charged at a standard hourly rate in 15 minute increments. Preparation of any correspondence with any professional, teacher, or administrator involved in your child's care, is similarly billed in this manner. Please also note, that although I hope this does not happen, if you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs at a rate of $225, even if I am called to testify for another party.

BILLING AND PAYMENTS I am deeply committed to the clinical care I provide and hope that each family experiences my therapeutic practice and office procedures as seamless, beneficial, and fulfilling. As such, I do not require clients to take time to submit payment during their session, which allows me to focus on the quality of our work together while preserving the therapy time you deserve.
I securely encrypting and saving Credit, Debit, or Health Savings Accounts (associated with a debit card) to your Clinical File through my Merchant Processor, Therapy Partner. You may have one, or several, options saved, with one primary option designated as your default to process payment for all clinical services. You are free to update this information at any time.
You may certainly forgo this option if you prefer to pay with cash or check. At this time I am able to accept Visa, MasterCard, and Discover.
Therapy Partner's Electronic Payment Authorization form comprises the second half of the The Consent to Treatment Form that I will ask you to fill out before our first session.
At the end of each month, you will automatically receive a link via email to an insurance-ready statement via email from Therapy Partner. Statements are for all sessions billed for in the previous calendar month. If you are seeking out of network reimbursement from a healthcare plan, you may use this statement to do so. The statement will have procedure and diagnosis codes as well as all of my identifying clinical information needed for reimbursement.

CONTACTING ME Due to my work schedule, I am often not immediately available by phone. When I am unavailable, my phone is confidentially answered by voicemail. I will make every effort to return your call within 48 hours, with the exception of weekends and holidays.
If you are unable to reach me and feel you can't wait for me to return your call, contact your family physician or nearest emergency room and ask for the mental health professional on call. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.
I similarly attempt to respond to email correspondence within a 48 hour time frame. Because email is retained in the logs of both of our Internet Service Providers, an opportunity is allowed for it to become reviewable by System Administrators, if the need arises. Although this is relatively uncommon, I prefer to keep these exchanges to scheduling and logistics, while limiting the inclusion of any clinically sensitive dialogue.
If you do choose to communicate private information via email or text, I will assume you have made an informed decision to do so, precluding any potential risks for it's interception, and honor your choice in moving forward in this manner. I allow Texting/SMS messaging for established clients, and am similarly inclined to keep any dialogue here limited solely to appointment purposes. I will follow your lead with the breadth of your choice of discretion used with this vehicle as well. All emails and texts sent to me are archived in each client's clinical file, becoming part of their legal record.

APPOINTMENTS Since I plan to be away from the office unless there is an appointment, it is very important that appointments be kept or, if they must be changed, that I be informed no later than the end of the previous business day. EXCEPT IN CASES THAT WE BOTH CONSIDER AN EMERGENCY, YOU WILL BE EXPECTED TO PAY FOR ALL TIME RESERVED FOR YOUR FAMILY UNLESS YOU PROVIDE 24 HOURS ADVANCE NOTICE OF CANCELLATION.

SOCIAL MEDIA POLICY As a component of my Pinterest Account, I maintain several visual boards linked to various Therapeutic Articles and Resources. You are welcome to view any of these boards at any time. Please, though, use your own discretion in choosing whether or not to follow me, noting that doing so may create some compromise to your confidentiality in terms of the privacy of our working relationship.
In a similar manner, I also choose not to add my current or former clients as friends or contacts, and not to answer any communication via social media outlets as confidentiality protocols. It is also my policy not to view any of your child's, or your personal, online content without consent, and without our explicit arrangement towards a specific purpose in doing so. I believe casual viewing outside the therapy hour could potentially create confusion over what you may feel my motives in reviewing this material might be, and may also blur the boundaries of our therapeutic relationship.
If there are posts or exchanges you'd like to share with me, please bring them into our session so we can view and explore them together.

INSURANCE PHILOSOPHY If you do wish to file for insurance reimbursement, you may furnish your insurance provider with the monthly emailed receipt showing that you have paid in full for services rendered. Payment is expected at the time of service and it will be up to you to mail receipts and to engage in any telephone or other negotiation. I recommend contacting your Health Care Provider prior to beginning treatment to familiarize yourself with deductible expectations and the percentage of services reimbursed through your Out of Network coverage. I make sure to provide comprehensive and insurance friendly receipts to ensure my clients an efficient reimbursement process.
If it does become necessary for me to become personally involved beyond furnishing you with a coded receipt, I bill in 15-minute increments at the rate that would apply to you for individual work with me, for any correspondence you may request.

LIMITS ON CONFIDENTIALITY The law protects the privacy of all communications between a patient and therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPPA. There are other situations that require only that you provide written, advance consent. Your signature on this Consent to Treatment indicates permission for those activities, as follows:

- I may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient or others, or there is a probability of immediate mental or emotional injury to the patient.

- While I certainly hope to not encounter this situation, Texas law authorizes us to provide information as necessary to collection agencies if other efforts to collect payment have failed.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the Counselor-Patient Privilege law. I cannot provide any information without you (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me to disclose information.

- If you tell me of a sexual involvement with a mental health professional who was involved in your care, I will report this to the appropriate State Board.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are a necessary attempt to protect others from harm, in which I may then have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is the victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information.

- If I determine that there is probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental, or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, I will make every effort to discuss it with you before taking any action and I will limit my disclosure when necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The law governing confidentiality can be quite complex, therefore in situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS In addition to your Clinical Record, I have the option of maintaining Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to me that is not required in your Clinical Record. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that release would be harmful to your physical, mental, or emotional health.

PATIENT RIGHTS HIPPA provides you with several new or expanded rights to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you neither consented nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

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NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR MENTAL HEALTH

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes with your consent.
To help clarify these terms, I've provided some ways that I might define each, relating to your care:
"PHI" refers to information in your health care record that could identify you.
TREATMENT is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment is when I consult with another health care provider, such as your family physician, social worker, therapist, psychologist, or psychiatrist.
PAYMENT is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to any third party payor to obtain reimbursement for your health care or to determine eligibility or coverage.
HEALTH CARE OPERATIONS are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
"USE" applies to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"DISCLOSURE" applies to activities outside my office, such as releasing, transferring, or providing access to information about you to other parties.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained.
An AUTHORIZATION is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing the information. I will also need to obtain an authorization before releasing your psychotherapy notes.
PSYCHOTHERAPY NOTES are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition obtaining insurance coverage, and the law provides the insurer the right to contest claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:
CHILD ABUSE: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must by law make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or any local or state law enforcement agency.
ADULT AND DOMESTIC ABUSE: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
ABUSE BY A THERAPIST: If I have cause to believe that you have been the victim of sexual exploitation by a mental health professional during the course of treatment, I will report this to the appropriate State Examining Board.
HEALTH OVERSIGHT: If a complaint is filed against me with the Texas State Board of Social Work Examiners, they have the right to subpoena confidential information from me pertaining to that complaint
JUDICIAL OR ADMINISTRATIVE PROCEEDINGS Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release the information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
SERIOUS THREAT TO HEALTH OR SAFETY: If I determine that there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
WORKERS COMPENSATION: If you file a worker's compensation claim, I may be asked to disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. PATIENTS RIGHTS

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send information to another address.
RIGHT TO INSPECT AND COPY: You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
RIGHT TO AMEND: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
RIGHT TO AN ACCOUNTING: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your request, I will discuss with you the details of the accounting process.
RIGHT TO A PAPER COPY: You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

V. MY DUTIES

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
If I revise my policies and procedures, I will provide you with a new copy at your next visit or by mail.

VI. QUESTIONS AND COMPLAINTS

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me. If you believe your privacy right shave been violated or wish to file a complaint with me, you may send your written complaint to me at the address provided on my letterhead. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VII. EFFECTIVE DATE, RESTRICTIONS & CHANGES TO PRIVACY POLICY

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at your next visit or by mail.

Created 4/2/2007
Last revised 1/11/2016

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Addendum to CONSENT to TREATMENT

Your signature below indicates that you

- have read and understood the information in this document
- agree to abide by its terms in our professional relationship
- have received and reviewed a copy my Notice of Privacy and Practices, and
- consent to treatment with me

_____ _____
Responsible party's printed name Responsible party's signature

_____ _____
Child's printed name Date

Therapy Partner ELECTRONIC PAYMENT AUTHORIZATION FORM

Please complete the following information if you are choosing to pay with a Credit or Debit card.. Forms of payment accepted: Visa, MC, & Discover.
Charges for all services rendered will be deducted from the account designated below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored in your clinical file. This information may be updated upon request at any time. Payments are processed by Therapy Partner, a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Responsible Party for Client

_____

Responsible Party's DOB

_____ / _____ / _____

Billing Address (as registered with Credit Card Company/Bank)

_____ City _____ State _____ Zip _____

Email (address you would like statements sent to) _____

FORM OF PAYMENT Please indicate the type of payment you prefer to use for services rendered through this practice.
(PLEASE CIRCLE ONE OF EACH IN EACH OF THE FOLLOWING BOXES)

Cash/Check or HSA (Health Savings Account) Debit Credit

Visa MasterCard Discover

Card # _____ Exp _____ 3 digit s.c. _____

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

_____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____
Authorized Cardholder Signature Date

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Name of parents or legal guardian _____

Line of work: Mother _____ / Primary Parent Father _____ / Primary Parent

Name of child _____ What does your child preferred to be called? same / _____

Child's age _____ Date of birth _____ / _____ / _____ Grade _____ Grade child would be in for DOB? same / _____

Home Address _____ City _____ Zip _____

Home phone (N/A) / _____ OK to leave message? (Y / N)

Cell Mom _____ OK to leave message? (Y / N) Email _____

Cell Dad _____ OK to leave message? (Y / N) Email _____

Cell Adolescent _____ / (N/A) Is it ok for me to directly coordinate with, if driving themselves to appts? (Y / N)

School Child Attends _____ Homeroom / Advisory Teacher _____

Principal / Headmaster _____ School Counselor _____

Please list any outside of school activities:

1) _____ on day(s) of week M / T / W / Th / F / Sa / Su

2) _____ M / T / W / Th / F / Sa / Su 3) _____ M / T / W / Th / F / Sa / Su

Name of siblings that live in the home: (please indicate if half or step when appropriate) or (N/A) Only Child

Name _____ Age _____ (Half / Step) Name _____ Age _____ (Half / Step)

Name _____ Age _____ (Half / Step) Name _____ Age _____ (Half / Step)

Name of referring professional _____ (N/A) Pediatrician _____

Psychiatrist _____ / (N/A) Neurologist _____ / (N/A)

TREATMENT GOALS

What is the one most concerning thing, above everything else, I can address with your child at this time?

_____

Please describe additional frustrations or worries about your son or daughter that I may be able to help with

_____

_____

What do you think your child would tell me they wanted to work on? _____

What are some areas that I might be able to help you in fine tuning, concerning parenting solutions or from a behavior management standpoint?

_____

_____

Ultimately, if you felt our sessions together were successful, what would your child look like at the end of our work together?

_____

_____

_____

THE FOLLOWING ARE SUPPLEMENTAL QUESTIONS THAT OFTEN ASSIST ME IN DIAGNOSTICALLY HONING IN ON, OR TEASING OUT, CERTAIN BEHAVIORAL PATTERNS IN YOUR CHILD. I APPRECIATE ANY EFFORT IN RECORDING WHAT RECOLLECTIONS, IMPRESSIONS, OR FEELINGS THAT YOU MAY HAVE.
PLEASE FEEL FREE TO CIRCLE WITHIN THE SENTENCE, ITEMS THAT MAY PARTICULARLY RELATE TO YOUR CHILD.

EARLY CHILDHOOD / DEVELOPMENTAL

Did your child experience reflux, colic, or significant allergies during his or her first 6 months? N / Y

Does your child currently experience allergies and/or asthma? N / Y

Did your child experience night terrors? N / Y If yes, please describe _____

Did your child have problems with bed wetting? N / Y Is the bed wetting resolved? N / Y Age resolved _____

Do you feel your child demonstrates, or demonstrated, any hyper-sexual behaviors for their age at any time? (i.e., preoccupation with your body parts, their body parts, wanting to see you or siblings naked, self stimulation)

N / Y / ? _____

Was your child ever sensitive or over-reactive to textures of clothing (jeans/corduroy), ridges in socks, tight waistbands, tags in shirts, strong smells, loud noises (public restroom toilettes/movie theaters), and/or your physical touch?

N / Y _____

Have there been any psychological, neurological, speech, OT, or educational evaluations completed on your child to date?
Please indicate the referral source prompting the testing, where and by whom testing was done by, and year testing was completed.

Previous diagnosis(s) made? (if you would like to share at this time) / N/A

Are there currently any 504 Modifications in place for your child? N / Y When were they put into place? _____

Please list any current nutritional supplements and/or vitamins that your child is taking

SELF SOOTHING & COPING STYLES

How would you say your child generally responds when he or she ...

experiences an "unwelcome" change in plans _____

does not pick up a new skill "well" _____

is (appropriately) blamed for something _____

What does a typical meltdown with your child look like? (i.e., what do they usually say to you, where do they go (or not go), what do they do with their bodies, how long does it typically take them to calm)

What consequences seem to affect your child the most?

1) _____ 2) _____

3) _____ 4) _____

What would say are the biggest power struggles between you and your child?

1) _____

2) _____

Thank you so much for your time in completing for me.

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Authorization for Exchange of Information

If you believe that it may become beneficial for me to speak with anyone else that has been, or currently is, involved in your child's care please identify these professionals below.
Listing and individual does not necessarily indicate that you are requesting contact and engagement, just legally authorizing that dialogue to happen in the future if the need arises, or you specifically request me to do so.

Your Child's Full Name _____ Date of Birth _____

Child's Primary Address _____

I hereby authorize Christina M. Rogers, LCSW to exchange information with:

Name of Professional _____ Phone _____

Address _____ Email _____

Name of Professional _____ Phone _____

Address _____ Email _____

Name of Professional _____ Phone _____

Address _____ Email _____

PLEASE FILL OUT THE FOLLOWING IF YOU WOULD LIKE ME TO PUT PARAMETERS AROUND THE DATES OF SERVICE DISCUSSED, OR RESTRICTIONS ON THE TYPES OF INFORMATION TO BE SHARED.
Information about me, or about the individual named above on whose behalf I am legally empowered to grant this authorization, concerning services provided on or about (dates if appropriate):

Dates: from _____ to _____

Restrictions on Information to be shared (if any):

_____

_____

Specify type of information to be shared:

_____

_____

_____

This authorization will be valid for one year from the date of contact with Christina Rogers' practice unless otherwise specified in the Restrictions section above. It may be revoked at any time, but only with respect to releases or exchanges that may occur following the revocation. I will not be able to revoke authorization regarding information that has already been released in good faith based on this authorization.

_____ _____
Authorized signature Date