Authorization to Exchange Protected Health Information

AUTHORIZATION: I give permission to[ ] or request from [ ] (please check one):

Name of Agency, Individual, or Health Care Provider:		
Address:	City/State:	Zip Code:
Telephone Number:	Fax Number:	Contact Name (if known):

To exchange information with:

Judy Kendall, M.A., LMFT
P.O. Box 6325
Albany, CA 94706

Telephone: (415) 747-5411
Facsimile: (415) 729-1838
judykendallMFT@gmail.com

The information, as identified below, relates to the following client:

Name (*print first name, middle initial and last name*):	Date of Birth (*month/day/year*):

INFORMATION: The following information is requested:
Important: Check the appropriate box or boxes and initial or sign and date as required.

☐ Records relating to ____
☐ Records [Date(s)]: From ____________________ To _____________________
☐ Attendance Only Records
☐ Billing or Payment Information/Records
☐ Consultation Reports
☐ Diagnosis
☐ Discharge Summary
☐ Medication(s)
☐ Medical, Neurological Assessment or Lab Tests (*EEG, EKG, etc.*)
☐ Progress Reports
☐ Psychiatric/Psychological Assessment
☐ Treatment or Personal Service Plan
☐ School records

** Medical records may include information related to alcohol/drug or mental health treatment or diagnosis and/or results of an HIV or STD test. However, if you do not check the box(es) below, the information will not be released with your entire medical record. If you check any of the boxes below, additional legal requirements regarding the information may apply before release can be made.*

☐ Entire Medical Record _____ (Initials Required)
Client authorizes the release of the following information:
- ☐ Alcohol/Drug Treatment ______________________(Signature/Date Required)
- ☐ Mental Health Treatment ______________________(Signature/Date Required)
- ☐ Results of an HIV Test ______________________(Signature/Date Required)
- ☐ Results of an STD Test ______________________(Signature/Date Required)

☐ Others ____
☐ *Verbal Communication Only* *(name and phone number)*

Client Name (print first name, middle initial, last name):	Date of Birth (*month/day/year*):

PURPOSE: The information may be used only for the following reason(s):

☐ For Continuity of Care	☐ To provide medical services
☐ For Treatment Planning/Case Management	☐ At the request of the client
☐ Other ______________________________	

RE-USE OF INFORMATION: I understand that if I authorize the release of my health information to someone who is not legally required to keep it confidential, that information may be shared with others and may no longer be protected. I also understand that under no circumstances am I required to authorize the release of psychotherapy notes.

CONDITIONS: I understand that I do not have to sign this Authorization form.
I understand that treatment, payment, enrollment and eligibility for benefits will not be based on my signing or refusing to sign this authorization, except if treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party.

RIGHT TO TAKE BACK AUTHORIZATION: I understand that I have the right to take back my authorization. If I take back my authorization, I have to notify my therapist in writing, I have to sign the notice, and I have to deliver the notice to my therapist in person or by mail at P.O. Box 6325, Albany, CA 94706.

The notice will be in effect when received by my therapist. Any information already shared by this authorization cannot be taken back.

EXPIRATION: This authorization will go into effect immediately and will remain in effect until ____________________________ (write in date). If I do not write in a date, this authorization will remain in effect for one year from the date of my signature.

Signature (*Client or Representative, as appropriate*)*:	Date (*month/day/year*):

** If form is signed by someone other than the client, state the relationship to client, and include required documentation of authority with the signed Authorization form.*

Name (*print*): ____

Relationship/ Authority:			
	☐ Parent	☐ Conservator	☐ Personal Representative
	☐ Guardian	☐ Other ____________________	

Name of Clinician Who Receives this Form (*Print*):	Date (*month/day/year*):