## THE PSYCHOTHERAPY OFFICE OF DR. KELLY A. WILLIAMS

KELLY A. WILLIAMS, PSY.D., LMFT 15300 VENTURA BOULEVARD, SUITE 324 SHERMAN OAKS, CA 91403

## Authorization for Exchange/Release/Disclosure of Protected Health Information

Name of Client:	Date of Birth:
Address:	<del></del>
AUTHORIZES EXCHANGE/RELEASE/DISCLOSI INFORMATION BETWEEN:	URE OF PROTECTED HEALTH
The Psychotherapy Office of Dr. Kelly A. Williams AND C/O Kelly A. Williams, Psy.D., LMFT 15300 Ventura Blvd., Suite 324 Sherman Oaks, CA 91403 818.928.5165	Name of Health Care Provider/Other
	Street Address
	City, State, Zip Code
	Telephone / Fax
INFORMATION TO BE EXCHANGED/RELEASD/DISCLOS Diagnosis Initial Assessment	
Treatment Plan Treatment Summa	ary Discharge Summary
Other (Specify):	
PURPOSE OF EXCHANGE/RELEASE/DISCLOSURE: (Plea To coordinate care with another practitioner	
To coordinate with legal representative	Other (Specify):
I understand that by providing my signature and authorized Information, may not be further used or disclosed by the required or permitted by law.	
<b>EXPIRATION DATE:</b> This authorization is valid until the f	ollowing date:/
*YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZAT You have a right to receive a copy of this authorization authorization, which I am not required to do, I must be proright to revoke this authorization. I understand that I have by notifying my treatment provider in writing. I may use the form and mail or deliver the revocation to my Therapist (so that a revocation will not affect the ability of my treatment or disclose the health information for reasons related to punderstand that I may refuse to sign this authorization with had the opportunity to review and understand the content authorization, I am confirming that it accurately reflects by	n: I understand that if I agree to sign this ovided with a signed copy of the form. You have a ave a right to revoke this authorization at any time he Revocation of Authorization at the bottom of this see address at the top of the page). I also understand t provider or any other health care provider to use rior reliance of this authorization. Conditions: I thout affecting my ability to obtain treatment. I have t of this Authorization form. By signing this
Signature of Client/Legal Guardian:Relationship to Client:	Date:/
Revocation of Aut	thorization
Name of Client:	
Signature of Client/Legal Guardian or Representative:	Date:/
Relationship to Client:	

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## Authorization for Exchange/Release/Disclosure of Protected Health Information

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Name of Health Care Provider/Other	AND The Psychotherapy Office of Dr. Kelly A. Williams C/O Kelly A. Williams, Psy.D., LMFT 15300 Ventura Blvd, Suite 324 Sherman Oaks, CA 91403 Tel. 818.928.5165
Street Address	
City, State, Zip Code	
Telephone / Fax	_
INFORMATION TO BE EXCHANGED/RELEASI Diagnosis Initial A	D/DISCLOSED: (Please initial) ssessment Dates of Treatment
Treatment Plan Treatme	ent Summary Discharge Summary
Other (Specify):	
PURPOSE OF EXCHANGE/RELEASE/DISCLOS To coordinate care with another practition	URE: (Please initial) oner Client is requesting release for individual reasons
To coordinate with legal representative	Other (Specify):
	d authorizing the exchange/release of Protected Health ed by the recipient unless such use or disclosure is specifically
<b>EXPIRATION DATE:</b> This authorization is valid	until the following date:/
authorization, which I am not required to do, I right to revoke this authorization. I understa by notifying my treatment provider in writing. I form and mail or deliver the revocation to my T that a revocation will not affect the ability of my or disclose the health information for reasons runderstand that I may refuse to sign this authorization.	horization: I understand that if I agree to sign this must be provided with a signed copy of the form. You have a nd that I have a right to revoke this authorization at any time may use the Revocation of Authorization at the bottom of this herapist (see address at the top of the page). I also understand treatment provider or any other health care provider to use elated to prior reliance of this authorization. Conditions: I rization without affecting my ability to obtain treatment. I have the content of this Authorization form. By signing this
Signature of Client/Legal Guardian:Relationship to Client:	Date:/
	ation of Authorization  atative: Date: / /
Relationship to Client:	