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: _____

AUTHORIZES EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION BETWEEN:

The Psychotherapy Office of Dr. Kelly A. Williams **AND** _____
C/O Kelly A. Williams, Psy.D., LMFT Name of Health Care Provider/Other
15300 Ventura Blvd., Suite 324 _____
Sherman Oaks, CA 91403 Street Address
818.928.5165 _____
City, State, Zip Code
_____
Telephone / Fax

INFORMATION TO BE EXCHANGED/RELEASD/DISCLOSED: (Please initial)

_____ Diagnosis _____ Initial Assessment _____ Dates of Treatment

_____ Treatment Plan _____ Treatment Summary _____ Discharge Summary

_____ Other (Specify): _____

PURPOSE OF EXCHANGE/RELEASE/DISCLOSURE: (Please initial)

_____ To coordinate care with another practitioner _____ Client is requesting release for individual reasons

_____ To coordinate with legal representative _____ Other (Specify): _____

I understand that by providing my signature and authorizing the exchange/release of Protected Health Information, may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: _____/_____/_____.

***YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

You have a right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **You have a right to revoke this authorization.** I understand that I have a right to revoke this authorization at any time by notifying my treatment provider in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to my Therapist (see address at the top of the page). I also understand that a revocation will not affect the ability of my treatment provider or any other health care provider to use or disclose the health information for reasons related to prior reliance of this authorization. Conditions: I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment. I have had the opportunity to review and understand the content of this Authorization form. By signing this authorization, I am confirming that it accurately reflects by wishes.

Signature of Client/Legal Guardian: _____ Date: _____/_____/_____
Relationship to Client: _____

Revocation of Authorization

Name of Client: _____

Signature of Client/Legal Guardian or Representative: _____ Date: _____/_____/_____

Relationship to Client: _____

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: _____

AUTHORIZES EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION BETWEEN:

_____
Name of Health Care Provider/Other
_____
Street Address
_____
City, State, Zip Code
_____
Telephone / Fax

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

INFORMATION TO BE EXCHANGED/RELEASD/DISCLOSED: (Please initial)

_____ Diagnosis _____ Initial Assessment _____ Dates of Treatment

_____ Treatment Plan _____ Treatment Summary _____ Discharge Summary

_____ Other (Specify): _____

PURPOSE OF EXCHANGE/RELEASE/DISCLOSURE: (Please initial)

_____ To coordinate care with another practitioner _____ Client is requesting release for individual reasons

_____ To coordinate with legal representative _____ Other (Specify): _____

I understand that by providing my signature and authorizing the exchange/release of Protected Health Information, may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: _____/_____/_____.

***YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

You have a right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **You have a right to revoke this authorization.** I understand that I have a right to revoke this authorization at any time by notifying my treatment provider in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to my Therapist (see address at the top of the page). I also understand that a revocation will not affect the ability of my treatment provider or any other health care provider to use or disclose the health information for reasons related to prior reliance of this authorization. Conditions: I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment. I have had the opportunity to review and understand the content of this Authorization form. By signing this authorization, I am confirming that it accurately reflects by wishes.

Signature of Client/Legal Guardian: _____ Date: _____/_____/_____
Relationship to Client: _____

Revocation of Authorization

Name of Client: _____

Signature of Client/Legal Guardian or Representative: _____ Date: _____/_____/_____

Relationship to Client: _____