AmyHamilton licensed marriage and family therapist 310.817.0203

4419 Van Nuys Boulevard • Suite 202 • Sherman Oaks, CA 91403
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License MFC #90278

AUTHORIZATION FOR EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

_____ _____
Name of Client Date of Birth

_____
Street Address City State Zip

AUTHORIZES EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION BETWEEN

Amy Hamilton, LMFT
4419 Van Nuys Blvd.
Suite 202
Sherman Oaks CA 91403
310.817.0203
License # MFC90278

AND:

_____
Name of Health Care Provider/Other

_____
Street Address

_____
City, State, Zip

_____
Phone/Fax

INFORMATION TO BE EXCHANGED/RELEASED/DISCLOSED:

❏ Diagnosis ❏ Patient Records ❏ Dates of Treatment ❏ Clinical Test Results
❏ Prognosis ❏ Progress to Date ❏ Treatment Plan ❏ Summary of Treatment
❏ Any and All Necessary Information
❏ Other: _____

PURPOSE OF EXCHANGE/RELEASE/DISCLOSURE:

❏ Client's Request: _____
❏ Other (specify): _____
_____

I understand that by signing and authorizing the PHI exchange/release/disclosure 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:
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. **Right to Revoke This Authorization:** I understand that I have the right to revoke this Authorization at any time by providing my request in writing. I also understand that a revocation will not affect the ability of Therapist or health care provider indicated herein to use or disclose the health information for reasons related to the 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 an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of client/legal representative: _____
Date

Relationship to client: _____