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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I, **(name of patient)** _____, (hereinafter "Patient") hereby authorize Scott M. Williams, PhD, LMFT, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at: 11145 Tampa Ave., Suite 12B, Porter Ranch, CA 91326 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:_____

The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to)**:

_____

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

Provider shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.
Patient understands that information used or disclosed pursuant to this authorization may **be subject** to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Patient's signature:_____ Date: _____