# Kindra L. Westercamp, Ph.D.
## Westercamp Counseling, LLC

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## AUTHORIZATION FOR RELEASE OR EXCHANGE OF PROTECTED HEALTH INFORMATION (PHI)

This form, when completed and signed by you, authorizes me to release/receive/exchange protected health information from your clinical record to/from/with the person(s) you designate.

I am completing this form to allow the use and sharing of protected health information about:

Printed Name:_____ Date of Birth: _____

I authorize my provider, **Kindra L. Westercamp, Ph.D.**,to release and/or exchange the following information: *(check all that apply):*

___ Copy of file or chart - *OR* -
___ Diagnosis/Diagnostic Impressions
___ Testing/Assessment Results
___ Prognosis/Impressions/Recommendations
___ Treatment Plan
___ Psychotherapy Notes
___ Other (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

_____
_____

This information should be released to, received from and/or exchanged with:
Name: _____
Address:_____
_____
Tel: _____ Fax: _____
E-mail: _____

I am requesting my provider to release/receive/exchange this information for the following reason(s):
_____
_____
*("at the request of the individual" is all that is required if you are my patient and you do not wish to state a specific purpose)*

I understand and agree that this authorization will remain valid and in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

_____
I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

I understand that I can revoke or cancel this Authorization at any time by sending a letter to my provider. If I do this, it will prevent any disclosures *after the date it is received* but cannot change the fact that some information may have been sent or shared before this date.

I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the provider listed above.

I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations.

My initials here in this box ☐ indicate that I affirm that anything in this form that was not clear to be has been explained adequately for my understanding. If requested, I received a copy of this completed form.

Signature of Client or his or her Personal Representative_____

Printed name of Client or his/her Representative_____Date_____

Nature of Relationship with Client (if signed by Representative)_____

Witnessed: _____ Date: _____

I, mental health professional, have discussed the issues above with the client and/or personal representative. My observations of his/her responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Professional Receiving Authorization_____

Printed Name _____ Date _____