Kathryn Kimball, Ph.D.
Evidence-Based Therapy Services

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AUTHORIZATION TO EXCHANGE/DISCLOSE INFORMATION

I, _____ (*Print Client/Legal Guardian's Name*), give my authorization to permit **Kathryn Kimball, Ph.D.** to request and exchange *confidential* professional information with the following health practitioner, clinic, office, agency, or institution(s) named below and/or receive any relevant information from them:

Name:_____

Address:_____

Phone: _____ FAX: _____

☐ Information to be used /disclosed includes either, all health information pertaining to my medical history, mental or physical condition, and treatment received.

OR

☐ Only the following records or types of health information (including any dates):

_____

_____

By signing this Authorization, you may be directing me to disclose your health information to a person or organization that may not have the same obligations to protect privacy required of health care practitioners, health plans, and other health care entities observed under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

I have the right to revoke this authorization at any time. This authorization will expire a year after termination of treatment, unless revoked in writing earlier or renewed.

I have reviewed and understand this Authorization. I understand that the information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. In consideration of this consent, I hereby release Kathryn Kimball, Ph.D. from any and all liability arising from contacts with the above-named parties.

Name (printed): _____

If applicable, on behalf of Minor's Name (printed): _____

Signature: _____ Date: _____