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AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ _____ DOB: _____

I authorize Sunah Kim, Psy.D. to release health information to:
Organization/Name: _____
Address: _____ City, State, Zip _____
Phone: _____ Fax: _____
Email: _____

□ Check here if you consent to an exchange of information between the above parties.
**If you elect to authorize to release information via, I will communicate via encrypted email.*

Please specify the information that you authorize to be released:

□ Mental health information
Related to: □ Treatment □ Evaluation □ Consultation
□ Summary Report □ Evaluation Report □ Progress Notes □ Entire records
□ Other (specify):
(subject to the Lanterman-Petris-Short Act, Welfare and Institutions code § 5000 et seq.).
□ I understand that raw data from psychological testing may not be part of the entire records for the objectivity, fairness, and integrity of psychological methods, unless mandated by court.
□ Medical
(This may include drug/alcohol and mental health information documented by a primary care practitioner)
□ Drug and alcohol abuse, diagnosis, or treatment information in a federal substance abuse facility (42 C.F.R. §§ 2.34 and 2.35)
□ HIV/AIDS test results (Health and Safety Code §120980 (g)).
□ Other:_____

Limitations upon disclosure: _____
_____

The purpose of this release is: _____
□ At the request of the client/guardian/representative

EXPIRATION OF THIS RELEASE
Date: _____
If no date is indicated, the authorization will expire upon termination of services provided by Sunah Kim, Psy.D.

_____ _____
Client/guardian/representative Signature Date:

_____ _____
Print Name Relationship to client

NOTICE: Sunah Kim, Psy.D. and many other organizations and care providers are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect your health information.
YOUR RIGHTS: The authorization to release information is voluntary. This authorization may be revoked at any time. The revocation must be in writing, signed by you or you/guardian/or representative, and delivered to Sunah Kim, Psy.D. The revocation will take effect immediately upon the recipient of your signed form. You are entitled to receive a copy of the authorization.