Mary Pat Kelly, Ph.D.
Clinical Psychologist
Lic. PSY 12662

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Authorization for Release/Exchange of Medical and Mental Health Information

Name of Patient	Date of Birth	Name of Patient's Legal Representative (*if applicable*)

Address	City	State	Zip	Phone Number

Authorization for Release/Exchange of Information: I voluntarily authorize and direct the health care provider named below to ☐release to or to ☐exchange my health information with the recipient identified below.

Name:	Mary Pat Kelly Ph.D.	Name:	_____
Address:	380 Glenneyre St. Suite D Laguna Beach, CA 92651	Address:	_____ _____
Phone:	(949) 494-0093	Phone:	_____
Fax:	(949) 497-0913	Fax:	_____

Type of Disclosure: ☐ Verbal Consultation ☐ Written Document ☐ Copies of Records

Specific Authorizations

I specifically authorize the release of the following information pertaining to the above named patient by checking and initialing next to the relevant box(es) below.

☐ _____ Mental Health information, diagnosis and treatment

☐ _____ Medical information, diagnosis and treatment

☐ _____ Drug and alcohol abuse information, diagnosis or treatment

☐ _____ HIV/Aids testing information

☐ _____ Correspondence and records from my other health care providers that the above named health care providers may hold

☐ _____ Disclosure will be limited to:_____

_____

_____

(complete reverse side)

Purpose of the Release: I understand that the specific purpose of this Authorization is:

☐ At the request of the patient/patient's representative
☐ Other (state reason/purpose)

_____

Additional Information if Applicable:

_____

_____

Expiration of Authorization: Unless otherwise revoked, this Authorization expires on _____. If no date is indicated, this Authorization will remain in effect for one year from the date this Authorization is signed.

Notice: Many organizations and individuals such as physicians, hospitals, and health plans are required by law to keep health information confidential. If you have authorized the disclosure of health information to someone who is not legally required to keep it confidential it may no longer be protected by state or federal confidentiality laws.

Your Rights: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

I understand that this Authorization will remain in effect until the term of the Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice. The revocation will not have any effect on any action already taken by my health care provider in reliance on this Authorization before my written notice of revocation is received.

I may contact my health care provider with any questions about the privacy of my health information. I understand that I have the right to receive a copy of this Authorization.

A photocopy, fax or electronic copy of this Authorization shall be considered as effective and as valid as the original.

_____	_____	_____
Name of Patient (PRINT)	Patient's Signature	Date

If patient named is not legally eligible (e.g., a minor) or otherwise unable to sign this Authorization, please complete the information below.

_____	_____	_____	_____
Name of Patient's Legal Representative (PRINT)	Legal Relationship to Patient	Signature of Patient's Legal Representative	Date

_____	_____	_____
Name Witness (PRINT)	Witness Signature	Date

I have the right to receive written acknowledgment from the non-medical recipient of the information being released pursuant to this authorization agreeing to abide by the restrictions contained in this release. By signing here I waive the right to receive such a signed written agreement from the intended recipient.

_____	_____
Signature of Patient or Patient's Legal Representative	Date