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AUTHORIZATION TO EXCHANGE HEALTH INFORMATION

This form specifies with whom information about you may be exchanged and for what purpose. If you have any questions about the form and how it is used, please ask Dr. McKellar.

My Authorization

I, ____________________________ , hereby authorize Dr. John McKellar to disclose/ release/exchange healthcare information and records obtained in the course of psychotherapy treatment with

Name ________________________________ Phone____________________________
Organization ____
Address ______________________________ City __________________ Zip _________

Reasons for this authorization:
- ☐ At my request
- ☐ Treatment coordination

Other ____
____

Dr. McKellar may exchange the following information:
- ☐ All my health information
- ☐ My health information relating to____
- ☐ My health information for the date(s)____
- ☐ Other____

This authorization ends:
- ☐ When my treatment with Dr. McKellar ends
- ☐ One year from date of signature
- ☐ On date___________________

My Rights

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 to address listed above. If I chose to revoke this authorization, it would not affect any actions already taken by my therapist based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that once my therapist discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Client's signature____ Date______________
(Or Guardian if in regard to minor)