Angela T. Williams, LCSW, Inc.
Licensed Clinical Social Worker (LCS 24723)
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Long Beach, CA 90807
(562) 439-5117 phone (562) 394-9211 fax

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Angela T. Williams, LCSW (LCS #24723) of ANGELA T. WILLIAMS, LCSW, INC. to disclose to and/or obtain from:_____

This exchange of information and records authorized herein is required for the following purpose(s): (Patient/Client should initial each item to be disclosed)

_____Coordination of care/treatment _____Coordination/allocation of benefits

_____Other _____

I understand that I have a right to receive a copy of this authorization. I also understand that I have a right to revoke this authorization, in writing, at any time. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

This authorization to release information, unless sooner revoked, expires on the following date:_____ (or 6 months from time of signing the form).

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient.

I have carefully read and I understand the foregoing information. I consent to the release of the above-specified clinical information for the purposes listed above. I further release ANGELA T. WILLIAMS, INC. and Angela T. Williams, LCSW noted from any liability incurred from the release or exchange of this information to the above designated persons or agencies.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Therapist Date