Loriene Honda, Ph.D.
Licensed Psychologist
PSY#19126

Authorization to Release Protected Health Information (PHI)

Client's Name: _____

Completion of this document authorizes the use and/or disclosure of my protected health information (PHI), consistent with California and Federal Law concerning the privacy of such information. My failure to provide all the information requested may invalidate this authorization.

I Authorize the Disclosure of My Health Information:

Between (Person/Organization authorized to disclose my information):

Loriene Honda, Ph.D.
613 G Street, Suite A
Davis, CA 95616

and (Person/Organization authorized to disclose my information):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Description of the Information to be Disclosed (circle all that apply beyond what is marked with an X**):**

Developmental Assessment X	Verbal Exchange of Information X	Psychological Testing and Assessment X
One Time	Ongoing X	Psychiatric Evaluation
Psychosocial Assessment X	Birth/Developmental History X	Substance Abuse Assessment
Birth Records from Hospital	Mental Health Treatment SummaryX	Demographic/Diagnostic Information for Billing Purposes

Purpose of Disclosure

Coordination of care

Sign Below When Read and Understood

I have the right to revoke this authorization in writing at any time. Dr. Honda has the right to rely on this authorization until such time I revoke it. This authorization shall not exceed one year and, if not earlier revoked, shall terminate on (date of event): _____

I have the right to refuse to sign this authorization. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I have a right to receive a copy of this authorization.
California law prohibits recipients of my health information from re-disclosing my protected information except with my written authorization or as specifically required or permitted by law.

I release Dr. Honda from any liability arising from the disclosure of this information to the above designated person or agency.

Sign below when read and understood.

Client's Signature: Date:

Authorized Representative Signature: Date:

Relationship (circle the one that applies): Parent Guardian

Other (specify): _____