



Aya Psychotherapy

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RELEASE OF INFORMATION FORM

This form when completed and signed by you, authorizes Shatina Williams, PhD. to release or receive protected information from your clinical record to or from the person you designate.

I authorize Shatina Williams, PhD. to exchange protected health information with the following parties. This information should only be released to or received from the following (name/address/phone/email):

I authorize my psychologist, Shatina Williams, PhD. to release and/or receive the following:

The purpose of the Requested Use or Disclosure is:

This Authorization shall remain in effect until (expiration date) _____ or until (fill in an event that relates to the individual or the purpose of the use or disclosure) _____. If this Authorization does not contain an expiration date, the Authorization expires 90 days from the date of my signature.

I understand:

- 1) My psychologist cannot redisclose information received from another health care provider if that health care provider requested that the information not be redisclosed.
- 2) My psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- 3) The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.
- 4) The client has the right to revoke this authorization, in writing, at any time; however, the revocation will not be effective if this authorization has already been exercised or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- 5) The client has the right to inspect the disclosed protected health information at any time.

_____ Client Name	_____ Client Signature	_____ Date
_____ Parent/Guardian Name (if client is a minor)	_____ Parent/Guardian Signature	_____ Date
_____ Witness Name	_____ Witness Signature	_____ Date