AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete all sections.

Section 1. I, _____(print name) authorize the following health care provider and/or organization to disclose the following protected health information to the designated person and/or organization for the purpose(s) listed below.

Section 2. Information disclosed by: Anil Coumar, MBBS, MA, LMHC / Swayam Prabha Psychological Services. 2113, NE 65th ST, Seattle, WA, 98115. Tel: 206-925-3158. Fax: 206-892-9705

Section 3. Information to be received by: _____
(name of person or organization)

_____
(address)

_____ _____
(fax number) or (phone number)

Section 4. The information to be disclosed:
___Mental health record
___Billing record
___Other (please specify)_____

Section 5. The information is to be:
___ mailed ____ faxed to _____
___ e-mailed_____ ____ phoned to _____
___ picked up by _____
___ Other (please specify) _____

Section 6. The information is disclosed for the following use(s):
_____

This authorization shall expire (date or event):
_____

Section 8. By signing below, I understand the following:

a. I may revoke the authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization) by sending a written revocation to the health care provider/organization designated above.

b. Any information disclosed by this authorization to any person/organization not a health care provider, business associate of a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.

c. I am entitled to receive a copy of this signed authorization.

Section 9. _____ _____ _____

Your Signature, Date of birth & Date signed