SCOTT CABOT WILLIS, PH.D., P.C
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AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

______________________________ ____________________

Patient Name Date of Birth

I, the undersigned, hereby authorize Dr. Scott Willis to send health information to and/or receive health information from:

Contact Person: ____

Agency: ____

Address: ____

____

Phone: ____________________ Fax: ______________________

This authorization for release extends to the care and treatment the patient received during (initial):

_____All dates of service, or _____ Service between ___________and___________.

This information may be used for the following purpose(s) (initial):

_____Evaluation, assessment and or treatment.
_____Ongoing coordination of treatment.
_____Other:

The information to be released is (initial):

_____School Transcripts/records
_____Treatment Plan or Summary
_____Psychological Evaluations/reports
_____Chemical Dependency Information
_____Diagnoses
_____Hospital Discharge Summary
_____Medical Evaluations
_____Test Results
_____HIV or AIDS Information
_____Psychosocial History
_____Other:____

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire (initial):

_____ One year from the date signed.
_____ On termination of mental health treatment.
_____ Other (specify):____

I have reviewed and I understand this Authorization. By signing this Authorization, you may be directing Dr. Willis to disclose your health information to another person or organization that may not have or obey the same obligations to protect privacy that he does under state and federal law. Therefore, the disclosure of the information specified above carries with it the potential for an unauthorized re-disclosure and loss of protection under state and federal law. I understand that Dr. Willis may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

____ __________________

Signature of Patient Date Signed

____ __________________

Signature of Patient Representative (parent, legal guardian) Date Signed