Patient Information

Client's Legal Name: First: _____ Middle: _____ Last: _____
c/o: _____
Client DOB: _____ Last 4 of SSN : _____
Address: _____
Phone Number: 1-_____- _____-_____ Email: _____

Authorization

I authorize Aya Psychological and Wellness Services, LLC/ Dr. Kenya L. King, PhD to:

☐Release to ☐Obtain from ☐Exchange with
Name of Person/Business: _____
Address: _____
Phone Number: 1-_____- _____-_____ Fax Number: 1-_____- _____-_____
Email: _____

the following information pertaining to the above named client

☐treatment summary
☐history/intake
☐diagnosis
☐psychological test results
☐psychiatric evaluation/medication history
☐dates of treatment adherence
☐Other (specify): _____
_____

for the purpose of

☐evaluation/assessment ☐coordinating treatment efforts ☐other (specify):_____

This consent will expire* on (Date:) _____ or when the following event occurs:

**If no expiration date, event, or condition is specified this authorization will expire 1 year from the date signed.)*

I understand that the protected health information specified above may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records. I have read and understand the following statements:

1. I understand that Aya Psychological and Wellness Services, LLC may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, Aya Psychological and Wellness Services, LLC will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that Aya Psychological and Wellness Services, LLC will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.
3. I understand that I may revoke this Authorization at any time by notifying Aya Psychological and Wellness Services, LLC in writing, in person, via phone, or email, but if I do, it will not have any effect on any actions Aya Psychological and Wellness Services, LLC took before it received the revocation.
4. I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.
5. I understand requests may be subject to a copying fee.
6. I understand that I may see and copy the information described on this form if I ask for it, and that I shall receive a copy of this form after I sign it if the request for disclosure was initiated by Aya Psychological and Wellness Services, LLC.
7. This authorization is valid for information created within 12 months after the date this authorization is signed, as well as past information. I understand it is my responsibility to notify Aya Psychological and Wellness Services, LLC to initiate follow-up requests based upon this standing authorization.

Client/Legal Guardian Signature _____

Client/Legal Guardian Printed Name _____ Date: _____

Witness Signature _____ _____ Date:_____