

Magdalene Holtam, PhD, PSY 23823
Richard Lam, MFTI, IMF 91288
2660 Solace Place, Suite A, Mountain View, CA 94040
Phone (650)209-0555 Fax 1(888)612-1035
www.mountainviewcounseling.com
magdalene.holtam@gmail.com

Consent to Release Confidential Information

1. I, _____ (print your name) am requesting the release of my protected health information.
2. I authorize Magdalene Holtam, PhD and Richard Lam, MFTI to disclose information regarding my psychological treatment to the person or organization listed below. I authorize Magdalene Holtam, PhD and Richard Lam, MFTI to 1.) receive information from this party or parties and 2.) provide information to this party or parties.
3. I authorize Magdalene Holtam, PhD and Richard Lam, MFTI to disclose the above noted information to this person and/or organization:
Name of Person or Organization: _____
Phone Number: _____
Full Mailing Address: _____
4. The information will be used/disclosed for the following purposes (e.g. continuity of care, referral, etc.):

5. I understand and agree that this Authorization will be valid for one year from this date unless specified otherwise here:

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new form.
6. I understand that I can revoke or cancel this authorization at any time through a written and signed request. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been disclosed before that date.
7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number 2, above, nor will it affect my eligibility for benefits.
8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, that Magdalene Holtam, PhD and Richard Lam MFTI cannot guarantee the ongoing privacy of the disclosed information.
9. I understand and agree that there may be administrative charges associated with the use or disclosure of my health information. The relevant financial arrangement has been explained to me and I understand and accept it.
10. I affirm that everything in this form that was not clear to me has been explained.

I, named client, agree to all of the above.

Signature of client or his or her personal representative

Date

Signature below indicates that the clinician has discussed the issues above with the client and/or the client's personal representative. My observations give me no reason to believe that this person is not fully competent to give informed/willing consent.

Signature of professional

Printed name of professional

Date

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