

Lisa A. Keller, Psy.D.

LICENSED PSYCHOLOGIST #PSY19547

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AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize the disclosure and exchange of treatment and academic information and records for patient known as _____ (hereafter "Patient") between:

Lisa A. Keller, Psy.D.

LICENSED PSYCHOLOGIST #PSY19547

16450 LOS GATOS BLVD., SUITE 212 LOS GATOS, CA 95032

and

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Dr. Lisa Keller has taken action in reliance upon it. And, I also understand that such revocation must be in writing.

This disclosure of information and records authorized by Patient is required for the following purposes:

The specific uses and limitations of the types of treatment and academic information to be disclosed are as follows:

Dr. Lisa Keller shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information. This authorization shall remain valid until:_____.

Patient/Legal Guardian

Signature:_____

Date:_____

Signature:_____

Date:_____