SEVITAR

Viveka Ramel, Ph. D.
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AUTHORIZATION TO EXCHANGE HEALTH INFORMATION

This form specifies with whom information about you may be exchanged and for what purpose. If you have any questions about the form and how it is used, please ask Dr. Ramel.

My Authorization

I, _____ , hereby authorize Dr. Viveka Ramel to disclose/ release/exchange healthcare information and records obtained in the course of psychotherapy treatment with

Name _____ Phone _____
Fax _____ Email _____
Organization _____
Address _____ City _____ Zip _____

Reasons for this authorization:
☐ At my request
☐ Treatment coordination
☐ Other_____
_____

Dr. Ramel may exchange the following information:
☐ All my health information
☐ My health information relating to_____
☐ My health information for the date(s)_____
☐ Other_____

This authorization ends:
☐ When my treatment with Dr. Ramel ends
☐ One year from date of signature
☐ On date_____
☐ No time limit

My Rights

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 to address listed above. If I chose to revoke this authorization, it would not affect any actions already taken by my therapist based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that once my therapist discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Client's signature_____ Date_____
(Or Guardian if in regard to minor)

Signature of Witness_____ Date_____

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ADDITIONAL RELEASE OF INFORMATION

Complete to allow your other provider(s) to consult with Dr. Ramel, if applicable.

In addition, I, _____, authorize _____ (name of other provider) to release clinical records and information pertaining to my mental health history, treatment and services to Dr. Viveka Ramel.

Client's signature_____ Date_____
(Or Guardian if in regard to minor)

Print name _____