Cyma B. Wilson, Psy.D.

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Authorization to Release Protected Healthcare Information (PHI)

Patient's Name: _____ Date of Birth: _____

Other Name (s): _____ Social Security #: _____

I request and authorize **Cyma B. Wilson, Psy.D.** and the following persons and/or entities to disclose, release, exchange, and use protected healthcare information of the patient named above to each other:

This request and authorization applies to all and each of the following:

Person/Agency	Address	Phone	Fax	Email

This request and authorization applies to:

- ☐ Protected Healthcare Information related to the following treatment, condition or dates:
- ☐ Reports and records concerning any drug and/or alcohol abuse care assessment and/or treatment, psychiatric and psychological assessment, counseling and/or treatment, and any infection, human immunodeficiency virus (HIV) infection, AIDS related complex (ARC), or acquired immune deficiency syndrome (AIDS), or any other infectious and communicable disease or condition.

I understand that this information is required for a mental health treatment and/or assessment.

Patient (Guardian)
Signature: _____ Date: _____

Witness (if any)
Signature: _____ Date: _____

This authorization expires after one year or at any earlier time you choose by giving written notice to Dr. Wilson, except to the extent that action has been taken in reliance on the authorization by any of the parties listed.