Dr. Karen Quek, PhD
Licensed Couple & Family Therapist #: 40805
Licensed Professional Clinical Counselor: #287
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EMPOWERING SELF, ENRICHING RELATIONSHIPS

Authorization for Release of Information

_________________________	_________________________	_________________________
Client's Name	Birth Date	SSN #
_________________________	_________________________	_________________________
Street Address	City	State, Zip Code

General Information Regarding this Authorization
I understand that this authorization is voluntary. This Authorization permits Dr. Karen Quek to use or disclose my Protected Health Information for purposes other than my treatment and payment of my services. I have the right to revoke this Authorization at any time by notifying Dr. Quek in writing. The revocation will be effective upon receipt except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.

I understand that I am not required to sign this Authorization as a condition to the provision of services.

I understand that once the requested information is disclosed pursuant to this Authorization, Dr. Quek will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA).

Authorization

I hereby authorize Dr. Karen Quek to (check all that apply):-

□Exchange with □Release to □Obtain from the parties I have indicated below

I hereby authorize Dr. Karen Quek to exchange/release/obtain information:

□Verbally only □In written form only (via email) □Both verbally and in writing (via email)

Person/Organization receiving/communicating the information:

Name: ___________________________________ Email: _____________________________________

Address: ____

____

Phone Number: ____

The purpose of this requested use or disclosure is

____

This Authorization shall expire on ________________, which is not more than one year after its effective date, unless it is revoked to the expiration date.

If applicable, please initial the appropriate blank in the following statements:

1. Alcohol or Drug Treatment Records. I do _____/I do not _____ authorize the use of disclosure of drug or alcohol abuse treatment records.
2. HIV Status. I do ______/I do not ______ authorize the release of HIV test results for the purpose set forth above.

_______________________________________ | _________________
Signature of Client or Legal Representative | Date Signed

_____________________________________ | _________________
Print Name of Legal Representative | Relationship to Client