Dr. James E. Walton, Ph.D.
Licensed Marriage & Family Therapist
6306 Babcock Ave., Valley Glen, CA 91606
(818) 753-4865 • LAtherapist.com

License # MFT 32040

Authorization for Release of Mental Health Information

Patient Information:

First and last name_____

Date of Birth_____

Address_____

Phone_____

Email_____

Provider's Information:

Dr. James E Walton, Ph. D.
6306 Babcock Ave
Valley Glen, CA 91606
818-753-4865
James@LAtherapist.com

By signing below, I hereby authorize and agree that Dr. Walton may discuss and/or disseminate _____'s personal health information (PHI) to, and receive that from, the following individuals and or entities:

Name of organization_____

Relationship_____

Address_____

Phone number_____

E-mail_____

Specify what information that Dr. James E Walton,Ph.D. may disclose, receive, share, and or discuss with the individuals or entities identified above by checking the corresponding boxes below.

All Mental Health Records_____

Number of Sessions Only_____

Progress Reports_____

Summary of Notes_____

Billing Information_____

Other_____

Description of Other_____

I understand I may revoke this authorization at any time by providing written notice to Dr. Walton. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless previously revoked in writing, this consent will terminate in 60 days following the completion of services.

I understand that authorizing the disclosure of information as voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and that the information may not be protected by federal confidentiality rules, and that Dr. Walton is not liable for any such redisclosure. Finally, I understand that Dr. Walton may refuse to share my information with the authorized individuals and entities named above. If, in the Dr. Walton's discretion, doing so would not be in the best interest of _____. If I have questions about disclosure of any information, I can contact Dr. Walton.

I have read the above forgoing authorization for release of information. And do hereby acknowledge that I am familiar with and fully understand and accept the terms and conditions of this authorization.

_____
Patient's Name (Print)

_____
Patient's Signature (or Guardian)

Support, Safety, Solutions

Date_____