MARILYN WILLIAMS, LPC-S, NCC

LICENSED PROFESSIONAL COUNSELOR

(LICENSED IN TEXAS • LOUISIANA • ALABAMA)

COUNSELING • ASSESSMENT • EVALUATION

RECIPROCAL RELEASE OF INFORMATION

I, ________________________________ , hereby authorize the use or disclosure of my protected health information as described below:

1. Authorized persons to use and disclose protected health information

______________________________________ (physician) is authorized to disclose the following protected health information to Marilyn Williams, LPC-S, NCC, of Lake Charles, Louisiana.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is: Any information needed for pre-bariatric surgery psychological evaluation.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is: Reciprocal Release of Information for the purposes of a pre-bariatric surgery psychological evaluation.

4. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on _____________________ (today's date) and expires one (1) year from that date, which is ________________________ (enter date one year from now).

5 ACKNOWLEDGMENT

I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED UNDER THIS AUTHORIZATION FORM MAY BE SUBJECT TO RE-DISCLOSURE BY THE PERSON(S) OR FACILITY RECEIVING IT AND WOULD THEN NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

I UNDERSTAND THAT MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS WILL NOT BE CONDITIONED ON WHETHER I SIGN THIS AUTHORIZATION.

I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM. IF SIGNED, I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME. I UNDERSTAND THAT ANY ACTION ALREADY TAKEN IN RELIANCE ON THIS AUTHORIZATION CANNOT BE REVERSED, AND MY REVOCATION WILL NOT AFFECT THOSE ACTIONS.

Name (signature): ____ **Date:** ________________