April Lok, Ph.D.
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Authorization for Release of Information

Client Name: ____ Date of Birth: _______________

I hereby authorize April Lok, Ph.D. to provide and receive confidential information to and from:

Name: ____

Organization: ____

Address: ____

City: ____ State: _____ Zip: _____________

Phone: ____

This includes verbal and written communication regarding treatment for the purposes of:

_____ Consultation, evaluation, or treatment, including coordination of care/services

_____ Billing/arranging for payment

_____ Research

_____ Other: ____

I understand that the information to be released may include information about mental health treatment and that once information is released from an entity covered by the Federal HIPAA Privacy Regulation, it may no longer be covered by that regulation.

I certify that this authorization has been made voluntarily and acknowledge that provision of services by April Lok, Ph.D. is not conditional upon my signature. In the event of my refusal or revocation of authorization necessary for Dr. Lok to receive payment from a third party, I will be responsible for payment of charges for services rendered. I may revoke this authorization at any time by notifying April Lok, Ph.D. in writing, except to the extent that action has already been taken while this authorization was in effect.

This authorization will expire on (if blank, one year from the date below): __________________

____ __________________

Signature Date

A photocopy or facsimile of this authorization is as valid as the original.