Michelle H. Murata, PsyD LLC

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Michelle H. Murata, PsyD LLC to release and/or receive the protected health information of

_____ _____
PATIENT'S NAME BIRTHDATE

To/From: _____
NAME OF PERSON, ORGANIZATION, OR FACILITY

_____ _____ _____
STREET ADDRESS, CITY, STATE, ZIP CODE PHONE NUMBER FAX NUMBER

For the following purposes:

Coordination of Care
At the request of the patient
Legal purposes
Other: _____

This authorization is in effect from the date of signature until _____. If no date or event is specified, the
DATE OR EVENT
authorization will expire one year from the date of signature.

By signing below, I understand that:

- I am authorizing the use or disclosure of my health information as described above for the purpose(s) listed.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I have the right to withdraw my consent for the release of my information at any time. If I choose to revoke my authorization, I must do so in writing, and I understand that it will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- The health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.
- I am releasing Michelle H. Murata, PsyD LLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Michelle H. Murata, PsyD LLC.

_____ _____
SIGNATURE OF PATIENT DATE

Or

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

Legal Relationship to Patient: _____