Kathleen Kawamura, PhD
Clinical Psychologist PSY 19507
(760) 295-3988

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Carlsbad, CA 92008

100 East San Marcos Blvd, Suite #404
San Marcos, CA 92069

Consent and Authorization to Exchange Confidential Information

I, _____, hereby authorize Kathleen Kawamura, PhD to release and
(name of client)
Exchange information with: _____
(name of person or organization to which disclosure is made)
_____
(address)
_____
(city/state/zip)
_____
(phone/fax number)

for the following reason: _____

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by Dr. Kawamura at 3105 El Camino Real Suite C, Carlsbad, CA 92008 or 100 East San Marcos Blvd, Suite #404, San Marcos, CA 92069 to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and signing of this authorization and Dr. Kawamura shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

This authorization is effective immediately and shall remain in effect until _____.
(This authorization will expire 12 months after the date signed unless otherwise specified).

Signature: _____ Date: _____
(*client or legal representative)*

Printed name of Legal Representative: _____
Relationship to client: _____

Signature: _____ Date: _____
Kathleen Kawamura, PhD