Dr. Christopher Willard (Psy.D.)
One Washington Street Suite 305
Wellesley, MA 02481
617.383.9355

Exchange of Information

Client Name: ___________________________________ Birth date: ________________

I request and authorize the healthcare information described below to be:
obtained from_____ and/or released to_______ Christopher Willard, PsyD

Name of person or organization	Address/ Phone Number
1.	
2.	
3.	
4.	
5.	
6.	

Time frame: The records or information is about health care provided during
- ❑ All dates of service
- ❑ The following approximate time frame: from _____________ to ________________

Purpose(s) of this use/disclosure: (*check all that apply*)
- ❑ At the request of the individual
- ❑ Treatment and/or follow-up
- ❑ Billing or payment operations
- ❑ Response to request for information
- ❑ Coordination of care
- ❑ Other: ________________

❑ **General Health Information**

I specifically authorize the use and/or disclosure of *(check one):*

❑ All health information pertaining to any medical history, mental or physical condition and treatment received unless one of the boxes below is checked.

❑ All health information pertaining to any medical history, mental or physical condition and treatment received *except*:

____

❑ Only the following records or type of health information (include dates):

____

Expiration Date: I understand that this authorization will expire at the termination of treatment with **Christopher Willard, PsyD** unless a specific date is noted in this space: ___________________

Revocation: I understand that I may revoke this authorization at any time by making a written request to **Christopher Willard, PsyD** This revocation will not have any effect on actions already taken in reliance on this authorization.

Refusal to Sign: I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Christopher Willard, PsyD (except when I am receiving research-related treatment or receiving health care solely for the purpose of creating information for disclosure to a third party).

Redisclosure: I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulation, except for substance abuse and alcohol information as noted above.

Consent: I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Signature:____ Date:_________________
Client (or Parent or Guardian)

Relationship to Client (if parent or guardian):_____________________

Separate Signatures are required for release of HIV status, substance abuse history or results of genetic testing

Information regarding alcohol or drug abuse

I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this will need my further written authorization to redisclose this information.

- Signature:_______________________________________ Date: __________________

Information regarding AIDS/HIV status

I specifically authorize the release of information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) status.

- Signature:_______________________________________ Date:____________________

Information regarding genetic testing

I specifically authorize the release of information regarding the results of a genetic test

- Signature:____ Date: ____________________

Revised 2/2016