KEVIN M. RAMOTAR, PSY.D.
CLINICAL PSYCHOLOGIST, PSY 26571

4350 EXECUTIVE DRIVE, STE. 255
SAN DIEGO, CA 92121

TEL: 661-524-5726
FAX: 858-754-1314

RELEASE OF INFORMATION

I, _____, hereby authorize **Kevin M. Ramotar, Psy.D.** to release and exchange information concerning my past and present medical and psychological conditions with:

_____

_____

_____

A PHOTOCOPY OF THIS FORM SHALL BE AS VALID AS THE ORIGINAL

The disclosure of information is required for the following purpose:

_____

Such disclosure shall be limited to the following specific types of information:

_____

I may revoke this authorization at any time. If not revoked, it expires on:

_____

I understand that I can revoke or cancel this authorization at any time.

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Client name _____

Client signature _____

Representative signature _____

If representative, relationship to client _____

Date _____

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

THE FOLLOWING SPECIFIES YOUR RIGHTS ABOUT THIS AUTHORIZATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED FROM TIME TO TIME ("HIPAA").

1. TELL YOUR COUNSELOR IF YOU DON'T UNDERSTAND THIS AUTHORIZATION, AND THE COUNSELOR WILL EXPLAIN IT TO YOU.

2. YOU HAVE THE RIGHT TO REVOKE OR CANCEL THIS AUTHORIZATION AT ANY TIME, EXCEPT: (A) TO THE EXTENT INFORMATION HAS ALREADY BEEN SHARED BASED ON THIS AUTHORIZATION; OR (B) THIS AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE. TO REVOKE OR CANCEL THIS AUTHORIZATION, YOU MUST SUBMIT YOUR REQUEST IN WRITING TO PROVIDER: **KEVIN M. RAMOTAR, 4350 EXECUTIVE DRIVE, SUITE 255, SAN DIEGO, CA 92121**.

3. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. YOUR REFUSAL TO SIGN WILL NOT AFFECT YOUR ABILITY TO OBTAIN TREATMENT OR PAYMENT OR YOUR ELIGIBILITY FOR BENEFITS. IF YOU REFUSE TO SIGN THIS AUTHORIZATION, AND YOU ARE IN A RESEARCH-RELATED TREATMENT PROGRAM OR HAVE AUTHORIZED YOUR PROVIDER TO DISCLOSE INFORMATION ABOUT YOU TO A THIRD PARTY, YOUR PROVIDER HAS THE RIGHT TO DECIDE NOT TO TREAT YOU OR ACCEPT YOU AS A CLIENT IN THEIR PRACTICE.

4. ONCE THE INFORMATION ABOUT YOU LEAVES THIS OFFICE ACCORDING TO THE TERMS OF THIS AUTHORIZATION, THIS OFFICE HAS NO CONTROL OVER HOW IT WILL BE USED BY THE RECIPIENT. YOU NEED TO BE AWARE THAT AT THAT POINT YOUR INFORMATION MAY NO LONGER BE PROTECTED BY HIPAA.

5. IF THIS OFFICE INITIATED THIS AUTHORIZATION, YOU MUST RECEIVE A COPY OF THE SIGNED AUTHORIZATION.