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Authorization to Receive, Use and/or Disclose Protected Health Information

I/We authorize Yanon Volcani, Ph.D., to obtain, exchange and/or release Protected Health Information about myself and/or my child(ren) with the following individuals and/or agencies. I also authorize the individuals and/or agencies to exchange and/or release Protected Health Information with Dr. Volcani:

Name	Relationship	Phone Number

This release shall include any information, psychological, psychiatric, medical, social and/or educational, which may pertain to myself and/or my/our child(ren), including, but not limited to any report, opinion, observation, test findings, record or other information for the purpose of completing a psychological or custody assessment, mediation, psychotherapy, or consultation. By signing this release, I recognize I am waiving any right to privacy between myself and the professionals, individuals, institutions, agencies, and/or schools herein authorized to communicate with Dr. Volcani per above. This authority extends to the furnishing of copies of all or any desired parts of the records pertaining to the above-mentioned person or persons.

Unless otherwise specified, this authorization will be valid for two years (specify alternate time period:_________________) from the date it is signed. I have been informed that I can have a copy of this release. I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to Dr. Volcani. However, my revocation or modification will not be effective until Dr. Volcani receives it by mail. If I do this it will prevent any releases after the date received, but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization, and that my refusal will not affect my ability to obtain services. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

I understand that if the persons or entities that receive the information are not health care providers or other entities covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I hereby release Dr. Volcani and the above named individuals from all legal liability that may arise from the release and sharing of the information requested. I affirm that everything in this form is clear to me – or if anything was not clear it has been explained – and I believe I now fully understand this form.

_______________________________________ ____________________

Signature of client or her/his representative Date

_______________________________________ ____________________

Printed name of client or her/his representative Relationship to client