K. Benjamin Knipe, Psy.D.
Licensed Psychologist 25758
(510) 460-8571
3120 Telegraph Ave, Suite 2A, Berkeley, CA 94705
dr.benjaminknipe@gmail.com • anxietyreliefandreferral.com

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Client Name:	DOB:	SSN:

I authorize K. Benjamin Knipe, Psy.D. to share written and oral information (two-way or reciprocal release) about my needs and the services I receive:

With the following persons, organization, or facility:

Individuals, Organization, or Facility:
Address:

Phone Number:	Fax Number:

PURPOSE OF DISCLOSURE:
Treatment Coordination

SPECIFIC INFORMATION FOR DISCLOSURE:
Entire Record [ ] or Specify: ______________________________
Drug/Alcohol Abuse, Diagnosis, Treatment (42 CFR 2.34/2.35) Initial__________
HIV/AIDS test results (HS 120980(g)) Initial__________
Genetic Testing Information (HS 124980(j)) Initial__________

Effective for dates beginning ______________ and expiring ______________
(if no dates are indicated, then Authorization will expire twelve [12] months from date form is signed)

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Limitations on Information to be shared: (attach additional sheet if nec.)

Notice
K. Benjamin Knipe, Psy.D. and many other organizations and individuals such as physicians, hospitals, health plans, and social services are required by law to protect the confidentiality of your health information. **If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal laws may no longer protect it.**

Your Rights
This Authorization to release health information is voluntary. For more information, please refer to our Notice of Privacy Practices.

You may revoke this Authorization at any time. Your revocation must be made in writing, signed by you, and delivered to K. Benjamin Knipe, Psy.D.

The revocation will take effect when K. Benjamin Knipe, Psy.D. receives it, except to the extent that K. Benjamin Knipe, Psy.D. has already released or shared information.

You are entitled to a copy of this Authorization.

Client Acknowledgement and Agreement
I acknowledge that I have read and fully understand this consent form.
My signature below shows that I understand and agree with all of these statements.

_______________________________________ _______________________
Signature of Client (or person acting for Client) Date

_______________________________________ _______________________
Printed Name Relationship to Client (if necessary)