DR. JULIE LOPEZ
Live Empowered

Health Information Release Form

Client's Name: _____ Date of birth: _____
Address: _____ Phone: _____

To: Dr. Julie Lopez , 1633 Q St NW, Suite 200 Washington, DC 20009

I, _____ hereby instruct Dr. Julie Lopez to release my protected health information in her custody to my primary therapist _____, for the purpose of their consulting together in connection with the proposed intensive time-limited therapy session ("intensive") I will participate in with Dr. Julie, including for pre- and post-intensive consultations.

Primary Therapist to receive my protected health information:

Name: _____ Affiliation: _____
Email Address: _____ Phone: _____

The information I wish to have released to Dr. Julie includes all records related to services provided at any time, including but not limited to, psychotherapy and background interview notes, physical and mental medical history, and any information about drug/alcohol abuse.

I understand the following:

A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
B. Information released in response to this authorization may be re-disclosed to other parties.
C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any electronic version, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization will expire one year from the date it is signed.

_____ _____
Signature of Client Date

_____
Signature of Witness

All items on this authorization must be completed in full. This form is designed to meet the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and related regulation.