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**Patient Authorization for Release of Protected Health Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Dr. Lara Kennerly, PsyD, to release/obtain information in my records, including diagnoses, treatment information, and other notations, to/from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I also authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to discuss my treatment if appropriate. This released information may be solely used for

purpose of clinical and medical treatment. This authorization is valid from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_