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**Authorization For Release of Information**

I, \_\_\_\_\_, hereby authorize Trysha LM Bodden, LMFT and  
Client Name  
\_\_\_\_\_, at \_\_\_\_\_ to exchange information.  
Name Telephone #

The type of information to be disclosed (check all that apply):

- Evaluations
- Diagnosis
- Treatment Plan
- Course of Treatment
- Other \_\_\_\_\_
- Medical/Hospital Records
- Psychological/Medical Test Results
- Mental Health Record Summary
- Psychotherapy Notes

Exceptions: \_\_\_\_\_

The designated information about me MAY/MAY NOT (circle one) be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Trysha LM Bodden, LMFT and the above designated person MAY/MAY NOT (circle one) discuss by telephone the content of the information released.

This consent is in effect until \_\_\_\_\_. I understand that I may revoke this  
Date  
authorization, in writing, at any time unless action based on it has already taken place.

**Authorization and Signature**

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing this information, if known, have been explained to me.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client or Personal Representative

If signed by a personal representative:

Print your name: \_\_\_\_\_

Indicate your relationship to the client and/or reason and legal authority for signing: \_\_\_\_\_

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING FURTHER DISCLOSURES OF THIS INFORMATION.