Ayama Psychotherapy LLC
720 Pike Street, Suite 2, P.O. Box 1122, Lemont, PA 16851
(814) 954- 7607, Fax (888) 965-1813
relax@ayamapsychotherapy.com

Ellen Dougherty, Ph.D.
Julie Pelletier, Ph.D.
J. Wes Scala, Ph.D.
Elana Szczesny, Ph.D.
Alissa S. Yamasaki, Ph.D.

Authorization for Release of Information

I, ___ ____________________, D.O.B.___________ permit _____________________________________
(Name of Client) (Therapist of Ayama)

to receive/provide (circle appropriate) information with ____________________________________, located
(Name of Contact)

at ____.
(Address of Contact)

Dates of service to be released: _________________________ to _______________________________.

Type of information to be exchanged:
___Mental Health
___HIV/AIDS/Sexually Transmitted Disease
___Drug/Alcohol Abuse
___Medication List
___General Medical Information
___MRI/CT scan
___Medical Problem List

Specifically:
___Progress Notes
___Treatment Summary
___Psychological Evaluation
___Neuropsychological Evaluation
___Other_____________________

For the purpose(s) of:
___Scheduling/Billing
___Conducting an evaluation
___Development of a treatment plan
___Treatment coordination
___Other (specify):____

Additionally:
___I would like a copy of this release.
___I decline a copy, as I know that I can always request a copy.

This release expires on _____________________________________ (or 1 year from today if not specified), whichever comes first. I also understand that I can request to revoke the release with a written request. By signing below, I understand that a revocation would not apply to information that has already been released. I also understand that this release is voluntary, and not needed in order to ensure healthcare treatment.

____ ___________________________
Client Signature Date

_____________________________________ _____________________________________ ___________________
Parent/Guardian Signature Printed Parent/Guardian Name Date

_____________________________________ _____________________________________ ___________________
Witness Signature Printed Witness Name Date

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