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Authorization to Disclose Protected Health Information

Patient's Name: _____

I hereby authorize _____("Provider")
to disclose to _____("Recipient)
(Name of person or entity to whom disclosure is to be made.)

The following protected health information either in writing or orally:

___Entire File ___Psychotherapy Notes ___Session Start/Stop Times
___Diagnosis ___Treatment Plan ___Symptoms
___Prognosis ___Progress to Date ___Clinical Test Results
___Modalities and Frequency of Treatment Finished
___Dates of Treatment
___Other_____

I understand that I have the right to receive a copy of this authorization and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless the Provider had taken action in reliance upon it. I also understand that such revocation must be in writing and received by the Provider to be effective.

I authorize the disclosure of the health information described above for the following purposes. _____

The Specific uses and limitations on the uses of my health information by the Recipient are as follows:

_____

_____

I understand that the provider cannot condition treatment upon me signing this authorization. I understand that the health information disclosed pursuant to this authorization may be subject to re- disclosure by the Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may by protected by applicable California law.

Provider is authorized to disclose the protected health information specifically listed above until _____

By:_____ **Date:**_____

(Patient/Patient's Representative(s) Signature

_____

(Patient/Patient's Representative(s) Printed Name)