



1633 Erringer Road, Suite 204 • Simi Valley, CA 93065 • 805-583-3976

Authorization to disclose protected health information

1. I am completing this form to allow the use and sharing of protected health information about

Printed name: _____ Date of Birth: _____

2. I authorize _____ (Provider)

3a. To use or disclose the following information:

- Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- Admission and discharge summaries
- Psychological or psychiatric evaluation(s), reports, assessments, routine progress notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Social, family, educational, and vocational histories
- Evaluations and reports of consultants
- Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- Billing records
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here Do not release these.
- Complete copy of the medical record.
- Other: _____

3b. Dates of care included: From _____ to _____

4. To this person or organization _____

5. The information will be used/disclosed for the following purposes:

6. I understand and agree that this Authorization will be valid and in effect until _____ [Enter a date or event upon which this Authorization expires.] I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

7. I understand that I have a right to receive a copy of the 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 in #2 above has taken action in reliance upon it. I also understand that such revocation must be in writing and received by the Provider to be effective. .

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits.

9. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

10. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

11. Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative's authority

12. ___ I acknowledge that I received a copy of this completed form

13. I, a mental health professional, have discussed the issues above with the client and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent

Signature of professional

Printed name of professional.

Date