Authorization to Disclose Protected Health Information

I hereby authorize _____
("Provider") to disclose to (name and function of the person or entity to whom disclosure is to be made) _____ ("Recipient")
the following protected health information:

____ Entire File ____ Psychotherapy Notes ____ Session Start/Stop Times
____ Diagnosis ____ Treatment Plan ____ Symptoms
____ Prognosis ____ Progress to Date ____ Clinical Test Results
____ Modalities & Frequencies of Treatment Furnished
____ Dates of Treatment
____ Other _____

I understand that I have a 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 Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:
_____
_____
_____

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

I understand that 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 Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

Provider is authorized to disclose the protected health information specifically listed above until:
_____ (authorization expiration date).

By: _____ Date: _____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her

Representative: _____