Authorization to Release/Exchange Confidential Information

I, ____, (*"patient" or "representative"*) hereby authorize the Ideal Living Psychology Center treatment team ("provider") to release or exchange protected health information obtained during the course of treatment to "recipient" named below:

Patient Name: ____

DOB: ____

Address: ____

City: __________________________________ State: ____ Zip: ___________

Recipient Name: ____

Title/ Company: ____

Address: ____

City: __________________________________ State: ____ Zip: ___________

Phone: ____

This Authorization permits the release or exchange of the following information: __ Entire File __ Psychotherapy Notes __ Dates of Service __Diagnosis __ Tx Plan __ Symptoms __ Prognosis __ Tx Progress __ Test Results __ Summary of Tx __Modalities & Frequencies of Tx __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 anytime 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 release/exchange of the information described above for the following purpose(s):*** ____

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:

Signature: ____________________________________ Date: ________________

"Client" or "Representative"

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

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