Must be complete for authorization to be valid

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Tamar Counseling Services

Records are protected by the California Welfare and Institution Code Section 5328: LANTERMAN-PETRIS-SHORT ACT
Records are also protected by the Federal Mandated HIPAA Privacy Regulations effective 4/2003

I hereby authorize the use of disclosure of my individually identifiable health information as described below.

Disclosure shall be limited to the Entity, information specified, and purposed as described below:

Client Name:

Date of Birth:

Date of Request:

Person / Organization Providing Information, Title, Phone Number, and Address:

Deborah Vinall, LMFT, PsyD
99 C Street, suite 203a, Upland CA 91786 (909)547-4878

Person / Organization Receiving Information, Title, Phone Number, and Address:

Description of Information Requested *(circle applicable)***:**
(diagnosis, medication history, psychological evaluation, treatment dates, initial / annual assessment, discharge summary, DCFS / court files, educational / vocational assessment, behavioral reports, treatment summary)

Purpose of Disclosure / Intended Use of Information:

The undersigned must read and initial the following:

_____ I understand that this authorization will expire on ___/___/___ (DD/MM/YY)
_____ I understand that this authorization entitles the party supplying the authorized information to disclose the fact and nature of their relationship to me.
_____ I understand that if the organization authorized to receive the information is not a health plan or health care provider, under that entity the released information may no longer be protected by federal privacy regulations.
_____ I understand that I am under no obligation to sign this form. Consent may benefit my therapy but is not necessary for my participation in therapy, nor will it affect pricing or payment.
_____ I understand that I may revoke this authorization by written notice at any time, although if I do this will not affect any disclosures made in accordance to this authorization that were initiated prior to the revocation.

* *Do not sign below until form is completed.*

Signature of Client or
Client's Representative: _____ Date: _____

Printed name and relationship of representative, if applicable (i.e. mother, attorney)

_____

Signature of Witness: _____ Date: _____