New Client Information

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name _____ First Name _____ MI ___

DOB: ___/___/___

Client Address: _____

Client Phone: _____ Cell / Home

Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____

Phone: _____

Address: _____

Date of Authorization: ___/___/_____ Authorization to expire on ___/___/_____

or upon the happening of the following event:

_____

Information to be Released (Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.) Check all that apply.

Dr. Nay Smith, LMFT, BCBA
2716 Ocean Park Blvd., Suite 1025
Santa Monica, Ca 90405
(310) 392-0835

□ My entire mental health record
□ Only those portions pertaining to: _____
□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)
Other:
_____
_____

Purpose of Information Release: Check all that apply.

□ Further mental health care
□ Applying for insurance
□ At the request of the individual
□ Payment of insurance claim
□ Legal investigation
□ Vocational rehab, evaluation
□ Disability determination
Other (specify):
_____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____
Signature Date

If signed by a personal representative:

(a) Print your name:
_____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: □ minor □ incompetent □ disabled □ deceased
Legal authority: □ parent □ legal guardian □ representative of deceased