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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH INFORMATION (HIPAA) FORM

Client Name: _____

My therapist, Mark E. Oakley, Ph. D., is authorized to release and disclose information to Name of person or organization _____ (if applicable) _____ (Name of person or organization) is authorized to release and disclose information to _____ (Therapist's name)

Specific Information to be released/obtained (Please select only one):

- ❑ All health/mental health information, including diagnosis and treatment received.
- ❑ Only the following records or type of information:

Please specify if any information is to be excluded: _____

_____

This disclosure of information authorized by Client is required for the following purpose: _____

This authorization shall become effective on __ / __ / __ and will expire in one year.
A photocopy of facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information, except with your written authorization or as specifically required or permitted by law.

Your rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to _____ (Therapist). Your revocation will be effective or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on your providing refusing to sign this Authorization.

Signature of Client/Parent/Guardian/Conservator: _____
Your relationship to the Client: _____ Date: _____