Authorization to Release Confidential Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document (both pages) before signing.

Patient Name:_____ Date of Birth:_____

Patient Address:_____

I hereby authorize: Crystal Earwood, LMFT #113418, Mind Body & Soul Therapy, 7828 Haven Ave., Ste 104, Rancho Cucamonga, CA 91730; 909-987-1658 (Phone Number), 909-481-5753 (Fax Number)

To **release** information (specified below) to: _____
(Insurance/Person/Organization to receive information) _____ (Address)
_____ (City, state, zip code)
_____ (Phone Number)_____ (Fax Number)

I authorize the release of the following health information (*select only one of the following*):
___ All health information about my medical history, mental or physical condition and treatment received; OR

___ Only the following records or types of health information (including any dates): _____
_____
_____

NOTE: The following types of information will not be released unless specifically authorized.

I specifically authorize the release of the following health information (*initials required if any of the following boxes are checked*):

___ Mental health treatment information Initial:_____

___ Alcohol / drug treatment information Initial:_____

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.
PURPOSE: The requested use or disclosure of my health information is for the following purposes:
(1) To provide and coordinate my health care treatment and services; and
(2) To improve the quality of health care that I receive.

EXPIRATION: This Authorization expires one year from the date of my signature unless a different date is specified here _____ (date).

REVOCATION: I understand that I may cancel this Authorization at any time, but I must do so by submitting my request for revocation to the Health Care Provider / Organization authorized to release the information. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION: I understand that I do not have to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits.

I understand that I have a right to receive a copy of this Authorization.

I further understand that information disclosed by this Authorization, may be redisclosed (given to) another person or agency and may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving my health information by this Authorization to disclose it, unless a new authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I have read both pages of this Authorization and agree to the use and disclosure of health information specified above.

Signature of Patient _____Date Signed_____
Signature of Patient's Legal Representative (if applicable)_____
Date Signed _____