*Kimberly A Gaines Counseling*

*39755 Murrieta Hot Springs Road, Suite D160*

*Murrieta, CA 92563*

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Client or Parent/Guardian of Minor Client, hereby authorize Kimberly Gaines, LMFT (hereinafter “Provider”) to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist’s diagnosis of Client, and to receive relevant information from the following person/organization:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider’s office address to be effective.

This disclosure of information/records authorized is required for the following purpose:

\_\_\_\_\_ Any and All Information Necessary \_\_\_\_\_ Diagnosis \_\_\_\_\_ Treatment Planning

\_\_\_\_\_ Prognosis \_\_\_\_\_ Progress to Date \_\_\_\_\_ Clinical Test Results

\_\_\_\_\_ Dates of Treatment \_\_\_\_\_ Patient Records \_\_\_\_\_ Summary of Treatment

\_\_\_\_\_ Consultation/Evaluation \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of the information described above for the following purposes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name (Printed)

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Parent/Guardian Name if Client is a Minor and Relationship to Minor (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Parent/Guardian’s Signature