Los Angeles Family Therapy

Authorization For Disclosure Of Mental Health Treatment Information

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____, authorize Zainy Pirbhai, Los Angeles Family Therapy Inc. to disclose to and/or obtain from:
_____

(Patient/Client should initial each item to be disclosed)

_____ Assessment

_____ Psychosocial Evaluation

_____ Psychiatric Evaluation

_____ Current Treatment Update

_____ Presence/Participation in Treatment

_____ Educational Information

_____ Continuing Care Plan

_____ Demographic Information

_____Other_____

_____ Diagnosis

_____ Psychological Evaluation

_____ Treatment Plan or Summary

_____ Medication Management Information

_____Nursing/Medical Information

_____ Discharge/Transfer Summary

_____ Progress in Treatment

_____Psychotherapy Notes* (*Cannot be combined with any other disclosure)

_____Other_____

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:_____
_____
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization