



Authorization for Use or Disclosure of Protected Health Information

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Phone: _____

Recipient Information

I, [printed name] _____, request that my protected health information (PHI) from [healthcare provider] _____ be disclosed to:

Abraham Aviles-Scott, LMFT
PO Box 372
Concord, CA 94522
aavilesscott@gmail.com
925-255-7704

Information to be Used or Disclosed

I authorize the following PHI to be released from my medical record(s):

- Entire Record
- Diagnosis
- Treatment Plan or Goals
- Other (specify): _____
- Treatment Progress
- Test Results
- Prognosis

Covering the period of healthcare from: _____ to _____

Disclosure Format

- Paper/Hard Copy (via U.S. Mail)
- Electronic (via E-Mail)

Purpose for Disclosure

- Further mental health care
- At the request of the individual
- Other (specify): _____



By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law.
- I have the right to **REVOKE** this authorization at any time. Revocation must be made in writing and presented or mailed to:
Abraham Aviles-Scott, PO Box 372, Concord, CA 94522
- Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **EXPIRE** on the following date/event/condition:

If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from the date signed.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure.
- I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the original.

Printed Name: _____

Signature of Patient or Authorized Representative: _____

Relationship to Patient (if applicable): _____

Date: _____