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 ☐ Treatment Progress

☐ Diagnosis ☐ Test Results

☐ Treatment Plan or Goals ☐ Prognosis

☐ Other (specify): ____

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: ____