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(619) 857-2870
Lic#17333

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By Client's signature below, this Authorization to Release Information (this "*Authorization*") authorizes Dr. Diane Ghiron ("*Provider*") to release to:

(Name of Entity or Person):_____

Address:_____

Phone: _____ **Fax:** _____ **Email:** _____

☐ **(Check this box if release is to be mutual)**

The following information:

- ☐ All Mental Health Treatment Records Including Evaluations, Testing and Progress Notes
- ☐ Treatment for Drug and Alcohol or other Substance Abuse
- ☐ Billing Records
- ☐ Treatment Summary
- ☐ Letter Requested by Client (Specify): _____
- ☐ Other (Specify):_____

Of: _____ ("*Client*")

Address:_____

Phone:_____ **Fax:**_____ **Email:** _____

The above information will be used for the following purposes:

- ☐ Treatment Planning
- ☐ Continuity of Care
- ☐ Case Review and/or Consultation
- ☐ Legal
- ☐ Personal
- ☐ Emergency Only
- ☐ Other: _____

This authorization will automatically terminate the earlier of one (1) year from the date of signing or on _____, unless previously revoked as set forth below.

NOTICE OF RIGHT OF REFUSAL TO SIGN

You may refuse to sign this authorization, and the execution of this authorization may not be made a condition of providing you with treatment.

NOTICE OF PROVIDER'S RIGHT TO WITHHOLD INFORMATION

The representative of a minor patient shall not be entitled to inspect or receive copies of a minor's patient records with respect to records for which the minor has a right of inspection, or where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being.[1] In response to a patient's request for their own records, Provider may choose under certain circumstances to prepare a summary of the record rather than allowing access to or copying of the record.[2] If Provider determines there is a substantial risk of significant adverse or detrimental consequences to the Client in seeing or receiving a copy of the mental health records requested above, Provider may decline to permit inspection or provide copies of the requested records. In such event, Provider will make a written record noting the date of this request and explaining Provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse detrimental consequences that Provider anticipates would occur to Client if inspection or copying were permitted. Provider shall permit inspection by or provide copies of the requested records to a licensed physician, licensed psychologist or other licensed behavioral health professional designated by Client.[3]

NOTICE OF RISK OF REDISCLOSURE

If you authorize the disclosure of health information to someone who is not legally required to keep it confidential, it may be potentially redisclosed and may no longer be protected.

NOTICE OF RIGHT OF REVOCATION

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or your legal representative, and delivered to Treatment Provider at its office address. You may deliver your revocation by any means you choose such as by personal delivery or U.S. Mail, but not by email, text messaging, or facsimile. Your revocation will be effective only when it is actually received. Your revocation will not be effective to the extent that Treatment Provider, or others have already acted in reliance upon this authorization.

NOTICE OF RIGHT TO COPY

You are entitled to a copy of this authorization and are encouraged to ask for one.

AUTHORIZATION

I understand and agree to the foregoing:

Date: _____

Client's Signature: _____

Print Client's Name: _____

Signature of parent or legal representative if Client is a Minor: _____
(Name) (Relationship)

[1] Cal. Health & Safety Code § 123115(a).
[2] Cal. Health & Safety Code § 123130.
[3] Cal. Health & Safety. Code § 123115(b).§

REVOCATION

I hereby revoke the authority given above.

Limitations of revocation: (If the revocation is to be limited, such as if you want Treatment Provider to stop disclosing some but not all of the information described above, please describe the limitations here. If you leave this part blank, this revocation will be treated as complete. Limitations: _____
_____

Date: _____

Client's Signature: _____

Print Client's Name:_____

Signature of parent or legal representative if Client is a Minor: _____
(Name) (Relationship)