FILE COPY ☐ CLIENT COPY ☐ OTHER PROVIDER COPY ☐

Authorization to Use or Disclose Protected Health Information

CLIENT INFORMATION

Client's Name: ______________________________ DOB: ______________________________

Address: ____

City: ____ State: ___________ Zip: ______________

I, **(Client Name):** ____,

hereby authorize New Focus Marriage & Family Counseling Inc., and staff member:

__________________________________, ("Provider"), to disclose, exchange, release information to/with:

RECIPIENT INFORMATION

Name ("Recipient"): ____

Business:____

Address: ____

City: ____ State: __________ Zip: ______________

Phone: ______________________________________ Fax: ______________________________

This agreement is in place:

From (today's date): _______________ to (date from 1 year from today): _______________________

Per our client's request, New Focus Marriage & Family Counseling Inc., will share the following protected health information with the above listed Recipient **(Please initial each box)**:

	Complete Mental Health Record **(requires a separate release)**		Psychotherapy Notes **(requires a separate release)**		Financial and billing information
	Diagnosis		Treatment Planning		Symptoms
	Prognosis		Progress to Date		Clinical Test Results
	Modalities & Frequencies of Treatment Furnished		Dates of Treatment		Other (specify)

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it 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. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:

____

The specific uses and limitations on the uses of my health information by Recipient are as follows:

____

I understand that Provider cannot condition treatment upon me signing this authorization.

Please read the following information carefully, do not sign if you are unclear about your rights. Your signature indicates that you understand the information and purpose for this release, your rights, and have had your questions answered to your satisfaction:

I understand this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

______________________________	______________________________	____________
Patient or Representative Name [Printed]	Signature	Today's Date
______________________________	______________________________	____________
Provider	Signature	Today's Date