
## AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, _____ (hereinafter "Client") hereby authorize PCBH, "Provider") to disclose, exchange, release mental health treatment information and records obtained in the course of my psychotherapy treatment, including, but not limited to therapist's diagnosis of
**Myself _____ My Child _____**

**to:** _____

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

I am requesting this disclosure of information and records for the following purpose:
**At the request of the individual: _____ Other: _____**

**The specific uses and limitations of the types of health information to be released are as follows: (Check all that apply)**
Treatment Coordination: _____
Treatment Summary: _____
Diagnosis: ___
Psychiatric Evaluation/Medication History: ____
Course of Treatment: ___
Evaluation: ____
Dates of Treatment/Attendance: ____
Other: ____

**For the purpose of:**

_____ Evaluation/Assessment and Coordinating Treatment efforts
_____ Other: _____

Such disclosures shall be limited to the following specific types of information:
**Name**
**Address**
**Telephone**
**Fax**

**Psychiatric diagnosis(es)**
**Dates of Treatment**
**Treatment Summary**
**Initial Treatment Plan**
**Full Treatment Record**

Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information. This authorization shall remain valid until: _____ **(not to exceed one year)**. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time **(except to the extent of that the information has already been released).**

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|---|---|---|---|
| **Printed Name of Client** | **Date** | **Printed Name of Witness** | **Date** |
| **Signature of Client** | **Date** | **Signature of Witness** | **Date** |