RACHEL MARKS, PSY.D.

Clinical Psychologist | PSY 22101

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/ EMERGENCY CONTACT ONLY

This authorization for use or disclosure of medical information complies with the terms of the Confidentiality of Medical Information Act, Civil Code Section 56 et seq; 42 U.S.C. Section 290 dd-2; 42 C.F.R. Section 2.1 et seq.; federal HIPAA regulations, 45 C.F.R. Section 164.508; and the Lanterman-Petris-Short Act, Welfare and Institutions Code Section 5328 et seq., and Health Insurance and Accountability Act of 1996 as applicable.

I hereby authorize (Name):_____Rachel Marks, Psy.D._____

To furnish:

▢ Assessment	▢ Entire File	▢ Psychological Testing Report
▢ Dates of Treatment	▢ Presenting Symptoms	▢ Prognosis
▢ Discharge Plans	▢ Progress To Date	▢ Treatment Plans & Recommendations
▢ Diagnosis	▢ Psychiatric Evaluation	▢ Other EMERGENCY CONTACT ONLY

To designee or representative of
(Name):_____

(Address & Phone):_____

I understand that information about the diagnosis of AIDS, as well as for the virus that causes AIDS and HIV may be released as part of the medical record. I agree to the release of this information. 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 continuation and follow-through of appropriate treatment. The specific uses and limitation on the uses of my health information by Recipient are as follows:

***EMERGENCY CONTACT ONLY**

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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.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under Federal Law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

Duration: this authorization shall be effective immediately.

I have carefully read and understand the forgoing. I consent to the release of the above-specified release of **Protected Health Information (PHI)**, which may include psychiatric illness and alcohol and/or drug abuse and dependence to those persons or agencies listed above. I further release my attending therapist, her associates from any liability arising from the release of this information or records to such designated persons or entities.

Restrictions: Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.
I understand that Provider cannot condition treatment upon me signing this authorization.
Provider is authorized to disclose the protected health information specifically listed above until: _____ (authorization expiration date).

_____ _____

Signature of Patient or Patient's Authorized Representative *Date*