

Authorization to Release Protected Health Information

I hereby authorize Jeanne Vattuone, LCSW to

- release
 exchange

protected health information with: _____

Name

Mailing Address

City, State, Zip Code

Phone

Method of disclosure and/or exchange:

- Verbal Copies of Records Letter Proof of Attendance
 Other _____

Types of information included:

- Any and/or All Information Necessary Diagnosis Treatment Plan
 Symptoms Dates of Treatment Summary of Treatment

I authorize the disclosure of protected health information for the following purposes:

The specific uses and limitations of my protected health information by Recipient are as follows: _____

I understand that Jeanne Vattuone, LCSW cannot condition treatment upon me signing this authorization.

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 Jeanne Vattuone, LCSW has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Jeanne Vattuone, LCSW to be effective.

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.

This authorization shall remain valid until: _____

Authorization Expiration Date

Signature of Client/Legal Guardian

Client/Legal Guardian Name (Print)

Date