RELEASE OF INFORMATION

I am completing this form to allow the use and sharing of protected health information about:

Name: Date of Birth

_____ exchange information with:

(Name, Address, Telephone), _____

_____ or obtain information from:

(Name, Address, Telephone), _____

My protected health information that may be used or disclosed includes: (**please initial)**
_____ Entire Medical Record
_____ Psychological/Psychiatric/Mental Health Assessment and History
_____ Psychotherapy Notes
_____ Medication History
_____ Progress, Case, or Office Notes
_____ Other: _____

I give special authorization for the following information to be used/disclosed: (**please initial)**
_____ Substance Abuse Information
_____ HIV/AIDS Information

Purpose of disclosure: _____

This authorization shall be effective until _____, or one year from the signature date, whichever comes first, unless I revoke it before that time. I understand that I can revoke or cancel this authorization at any time by sending a letter to Susan J Sabatini, MA, LMFT. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

I understand that this authorization is voluntary and that my refusal to sign will not affect my ability to obtain treatment from Susan J Sabatini, MA, LMFT. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I agree that a photocopy or facsimile copy of this signed authorization form is as valid as an original signed copy.

I have had the opportunity to review and understand the contents of this form. I understand that I am entitled to receive a copy of this authorization upon request.

_____

Client/Guardian **Date**