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AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Patient Name:_____ Date of Birth:_____

My Therapist, DR.CHERYL A. KEMPINSKY, is authorized to (*check all that apply):*

_____ Release or disclose records and/or information to
_____ Obtain or use records and/or information from
_____ Mutually discuss and exchange records and/or information

This information should only be released to:

_____, (Name)

_____, (Address/Phone)

Specific Information to be Released/Obtained (*Please select only one*):

_____ All health/mental health information including diagnosis and treatment received.

_____ Only the following records or type of information:

_____.

Please specify if any information is to be excluded:

_____.

This disclosure of information authorized is required for the following purpose:

_____.

I. I am giving my consent to release such information as of today's date for a period of :

_____, not to exceed _____(Date).

II. I understand that a photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this Authorization
- You may revoke this Authorization only by delivering your revocation in writing to Dr. Kempinsky. Your revocation will be effective when she receives it. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have a right to receive a copy of the Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

Name of Patient/Parent/Guardian (printed): _____

Relationship to the Patient: _____

Signature: _____

Date: _____

To Revoke Authorization Only:

Authorization Revoked on this Date: _____

Name (printed): _____

Signature: _____