Kristin Perry, MFT #48092

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize use or disclosure of the named individual's health information

CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:
THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO OBTAIN OR RELEASE PHI		
LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:		DATE:
THIS INFORMATION MAY BE OBTAINED OR RELEASED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION		
NAME OF ENTITY: Kristin Perry, MFT 2558 Roosevelt Street, Suite 201, Carlsbad, CA 92008 Phone & Fax: 760-978-6071 Please, call first to fax.		
TREATMENT DATES:	**PURPOSE OF REQUEST:** To coordinate behavioral health services.	
THE FOLLOWING INFORMATION IS TO BE DISCLOSED:		
X All records including, but not limited to: ☐ History and Physical Examination ☐ Discharge Summary ☐ Progress Notes ☐ Medication Records ☐ Laboratory results ☐ Psychiatric Records ☐ All Education records	☐ HIV/AIDS blood test results/references ☐ Physical Orders ☐ Billing records ☐ Drug/Alcohol Rehabilitation Records ☐ Case Management notes ☐ Other: ___________________________	

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:____
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

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

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.
I have right to receive a copy of this authorization. I would like a copy of this authorization.
□ Yes □ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
Signature of Client:	Date:
Signature of Parent/Guardian:	Date:
If signed by Legal Representative, Relationship of Individual:	
Signature of Provider Validating Identification:	Date: