JENNIFER S. BAILEY, MA, LMFT
LICENSED MARRIAGE AND FAMILY THERAPIST, MFC 52363
(818) 394-0890

10646 ZELZAH AVENUE
SUITE 207
GRANADA HILLS, CA 91344

AUTHORIZATION FOR EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of client: _____ Date of birth: _____

Street Address: _____

AUTHORIZES EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION BETWEEN:

Jennifer S. Bailey, MA, LMFT
10646 Zelzah Ave., Suite 207
Granada Hills, CA 91344
818-394-0890

AND:

_____
Name of Health Care Provider/Other

_____
Street Address

_____
City, State, Zip

_____
Phone Fax

INFORMATION TO BE EXCHANGED/RELEASED/DISCLOSED:

[ ] Diagnosis [ ] Patient Records [ ] Dates of Treatment
[ ] Clinical Test Results [ ] Prognosis [ ] Progress to Date
[ ] Treatment Plan [ ] Summary of Treatment [ ] Any and All Necessary Information
[ ] Other: _____

PURPOSE OF EXCHANGE/RELEASE/DISCLOSURE: (check applicable categories)

[ ] Client's request: _____
[ ] Other (specify): _____

I understand that by signing and authorizing the PHI exchange/release may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to receive a copy of this Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Revoke this Authorization:** I understand that I have the right to revoke this Authorization at any time by notifying my therapist in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to my therapist (see address at top of page). I also understand that a revocation will not affect the ability of my therapist or any other health care provider to use or disclose the health information for reasons related to the prior reliance of this Authorization.
Conditions: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of client/legal representative: _____ Date: _____
Relationship to client: _____

Revocation of Authorization

Signature of client/legal representative: _____ Date: _____
Relationship to client: _____