

Lorelei O'Neill, MA, LMFT 86784

Authorization to Disclose Protected Health Information

I hereby authorize Lorelei O'Neill, Licensed Marriage & Family Therapist Professional Corporation to disclose to (name and function of the person or entity to whom disclosure is to be made):

_____ ("Recipient") the following protected health information:

___ Entire File ___ Psychotherapy Notes ___ Session Start/Stop Times

___ Diagnosis ___ Treatment Plan ___ Symptoms

___ Prognosis ___ Progress to Date ___ Clinical Test Results

___ Modalities & Frequencies of Treatment Furnished

___ Dates of Treatment

___ Other

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

I authorize the disclosure of the health information described above for the following purpose:

The specific uses and limitations on the uses of my health information by Recipient are as follows:

I understand that Provider cannot condition treatment upon me signing this authorization. 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.

Provider is authorized to disclose the protected health information specifically listed above until: (authorization expiration date) _____.

By: _____
(Patient or Patient's Representative*)

Date: _____

*If signed by other than Patient, please indicate the relationship between Patient and his/her

Representative: _____