AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client/Patient Name: _____

SSN/ID: _____ Date of Birth: _____

I request and authorize the disclosure of mental health, medical, and substance abuse records and information about me between:

Bert H. Epstein, Psy.D. **AND**
115 Liberty Street Suite 5
Petaluma, CA 94952

(707) 242-1989

Name: _____

Address: _____

City, State, Zip: _____

Phone/Fax: _____

Information released/requested to include all checked below:

☐ Admission/Discharge Summary	☐ Psychological Testing	☐ Clinical Summary
☐ Medication Records	☐ Psychiatric Evaluation	☐ Progress Report
☐ History and Physical Exam	☐ Intake/Psychosocial History	☐ Laboratory Tests
☐ Termination Summary		

Other: _____

Information and records requested may include reference to my HIV/AIDS status:
◉ I do want it included ○ I do not want it included

Purpose of this disclosure: _____
(Examples: Coordination of Care, Evaluation, Academic Support, Documentation, Referral)

This authorization automatically expires in 180 days unless otherwise indicated.
Other date/event: _____

Revocation: The patient may revoke this authorization in writing at any time, except to the extent that Dr. Epstein has acted in reliance on this authorization. Revocation may be made in writing to Dr. Epstein and delivered to him as the privacy officer.

Re-disclosure: Information used or disclosed under this authorization will be given to recipients who may re-disclose the information and those later disclosures may not be protected by law.

Patient's Rights: The patient may inspect or copy the protected health information used or disclosed pursuant to authorization except when such disclose is a severe detriment to patient/client welfare.

To Recipient of Release: The information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Digital Signature (name, DOB): _____ Date: _____

If Client is under 18, Signature of Parent/Guardian: _____ Date: _____