**Authorization For Disclosure Of Mental Health Treatment Information**

**(HIPAA Release of Information)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ whose Date of Birth is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 [*Name of Client*], [*Month/Date/Year of Birth*]

authorize Nancy J. Lin, Ph.D. of Go to Sleep San Diego to disclose to and/or obtain from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the following information:

*[I Name of Person or Title of Person or Organization]*

**Description of Information to be Disclosed**

(*Client: Please initial each item to be disclosed*)

\_\_\_\_\_ Psychotherapy Notes\* (\*Cannot be combined with any other disclosure)

\_\_\_\_\_ HIV Status

\_\_\_\_\_ Alcohol or drug use

\_\_\_\_\_ Assessment

\_\_\_\_\_ Diagnosis

\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_ Treatment Plan or Summary

\_\_\_\_\_ Current Treatment Update

\_\_\_\_\_ Medication Management Information

\_\_\_\_\_ Presence/Participation in Treatment

\_\_\_\_\_\_Nursing/Medical Information

\_\_\_\_\_ Educational Information

\_\_\_\_\_ Discharge/Transfer Summary

\_\_\_\_\_ Continuing Care Plan

\_\_\_\_\_ Progress in Treatment

\_\_\_\_\_ Demographic Information

\_\_\_\_\_ Letter of Support including diagnosis, progress and/or dates of treatment

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I request the information to be sent to/obtained from:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\*Note: Messages originating from Go to Sleep San Diego by Nancy Lin will be sent as an encrypted message. However, HIPAA compliance cannot be guaranteed; recipient’s email may not be secure.)

**Purpose**

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose *is other than* as specified above, please specify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Revocation**

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Nancy J. Lin, Ph.D. at Go to Sleep San Diego. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration**

Unless sooner revoked, this authorization expires on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or as

 [month/day/year]

otherwise indicated.

**Conditions**

I further understand that Nancy J. Lin, Ph.D. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to

sign this authorization may have the following consequences:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Form of Disclosure**

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Redisclosure**

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client** **Date**

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**Signature of Guardian or Personal Representative** **Date**

\*If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_\_**Check here if patient/client refuses to sign authorization**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Staff Witness** **Date**

Updated on January 10, 2018.