AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Patient Name: _____ Cell/Work Phone: _____

Recipient's Name, Phone Number, Fax Number, and Address for Delivery of Records:

Authorization to Disclose Confidential Information: I voluntarily authorize and direct Bonnie Rose, MA, LMFT, whose office number is: 818-974-8828, to disclose confidential information during the term of this Authorization to the recipient that I have identified above.

Purpose: I understand that the specific purpose of this Authorization is

_____

Information to be Disclosed: This authorization permits Bonnie Rose to disclose the following information:

_____ All of my health information that Bonnie Rose has in his/her possession, including information relating to any, diagnosis, progress to date, treatment plan, prognosis, dates of treatment, clinical test results, including without limitation, HIV/AIDS status, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from other health care providers that Bonnie Rose may hold.

_____ All of my health information described above except for the following:

_____

_____ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Re-disclosure: I understand that once Bonnie Rose discloses my health information to the recipient identified above, Bonnie Rose cannot guarantee that the recipient will not re-disclose my health information to a third party.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Bonnie Rose at her email address. The revocation will be effective immediately upon Bonnie Rose's receipt of my written notice, except that the revocation will not have any effect any action taken by Bonnie Rose in reliance on this Authorization before she received my written notice of revocation.

Photocopy: A photocopy or electronic copy of this Authorization shall be considered as effective and as valid as the original.

Signature _____ Date _____ Signature of Witness _____