AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Patient Name: _____ Phone Number: _____

Recipient of Medical Records

Bonnie Rose, MA, LMFT

Email: Bonnie@Bonnierose.com

Phone: (818) 974-8828

Provider of Medical Records

Name: _____ Type of Provider: _____

Address: _____ Email:_____

_____ Phone: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the Provider of Medical Records (Provider) to disclose my health information during the term of this Authorization to the Recipient Identified above.

Purpose: I understand that the specific purpose of this Authorization is to preserve the continuity of care of my treatments and to allow the Recipient identified above to have a better understanding of my condition.

Information to be disclosed: This authorization permits the Provider to disclose the following information:

_____ All of my health information that the Provider 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 the Provider may hold.

_____ 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.

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 the Provider at his mailing address. The revocation will be effective immediately upon the Provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Provider 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 _____