Authorization to Release/Exchange Confidential Information

I, ____(“Patient”), hereby authorize Dr. Sandra Santana, Psy.D. (“Provider”) to release/exchange confidential information obtained during the course of my treatment to:

____(“Recipient”).

This authorization permits the release of and exchange of the following information, with above recipient:

_____ Assessment	______ Participation in Treatment
_____ Diagnosis	_____ Discharge/Transfer Summary
_____ Prognosis	_____ Progress in Treatment
_____ Psychological Evaluation	_____ Demographic Information
_____ Treatment Plan or Summary	______Other______________________
_____ Current Treatment Update	______Other______________________

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Dr. Sandra Santana, Psy.D. 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

The Authorization shall remain valid until: _________(“Expiration Date”) or unless otherwise revoked.

Form of Disclosure

Unless I have specifically requested in writing that the disclosure be made in a certain format, Dr. Sandra Santana, Psy.D. reserves the right to disclose information as permitted by this authorization in any manner deemed 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 Patient/Client Date

____ ___________

Signature of Parent, 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.).

____ __________

Signature of Staff Witness Date