Adrienne Levy, MA, MFT
2558 Roosevelt Street, Suite 204
Carlsbad, CA 92008
760-720-5320
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www.adriennelevy.com

Authorization for Release or Exchange of Protected Health Information (PHI)

_____ _____
Print Client's full name Date of birth

_____ _____
Address Phone Number

I (We) authorize the use and/or disclosure of protected health information (PHI) contained in my (our) clinical and billing records to be shared between the above named therapist, Adrienne Levy, MFT and:

_____
Facility/Provider

_____
Address

_____
Phone number

Types of information that may be shared include:

_____ Medical History _____ Educational _____ Legal Issues

_____ Diagnosis ____ Psychological Testing _____ Mental Health Evaluation

_____ Treatment goals and objectives _____Drug or alcohol treatment history

_____ Employment _____ Housing _____ Family History

_____ Other _____

Disclosure of this information is necessary for the following purpose:
_____

_____

A photocopy or fax of this release shall have the same force and effect as the original.

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Re-disclosure: Be advised, the above named therapist, Adrienne Levy, MFT, cannot guarantee the recipient of this information will not re-disclose it to a third party. The recipient *may* not be subject to federal laws governing privacy of health information. California law generally prohibits re-disclosure of PHI without specific written consent, except where it is permissible or mandated by law.

Right to Revoke: I understand that I have the right to revoke this authorization, **in writing**, at any time. I understand the revocation does not apply to information already released in accordance with this authorization.

Right to Receive a Copy of this Authorization: I understand it is my right to obtain a copy of this authorization. I wish to receive a copy. _____ Yes _____ No

Term: This authorization is valid:

_____ From today _____ until _____.
Today's date End Date

_____ Date this Authorization is revoked (if applicable): _____.

I (we) have read and understand the terms of this authorization. By my signature I (we) voluntarily give consent to disclose information in the manner described above.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (for minor child) or Authorized Representative Date

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Relationship to above mentioned minor child or description of authority concerning client otherwise unable to sign for him/herself

NOTICE TO RECEIVING FACILITY/THERAPIST/OTHER PERSONS:
You may not disclose any of this information without written permission from the person who has consented to this disclosure