Jacquelyn J. Bradbard, MSW, LCSW
428 W. Harrison Ave. Suite 101B Claremont, CA 91711
Phone (909) 624-4283, Fax (909) 625-7817

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF CLIENT: _____ DOB: _____

By signing this form, you give your consent to our use and disclosure of protected health information about you and/or your legal dependent for the specific purpose and in the specific manner described below. Federal health privacy laws (Confidentiality of Medical Information Act, 1981 & HIPAA, 1996) require that we obtain a signed and dated authorization from you for these uses and disclosures. We can rely on the authorization until you revoke it, or if you have not revoked it, until two (2) years have expired from the date of authorization. You can revoke this authorization at any time by delivering a dated and signed letter to our office at the location below. However, please be aware that your revocation will not prohibit us from (a) any acts we have already taken in reliance on the authorization, or (b) any right associated with an insurer's contest of a claim under its policy, if the authorization was in order to obtain insurance coverage.

Please note: (a) You can refused to sign this authorization. Your refusal will not affect your ability to obtain treatment; (b) If the persons you authorize to receive this information listed below are not health care providers or health plans covered by federal health privacy laws, they may re-disclose that information and those laws would no longer protect the released health information; (c) You may review with your clinician the protected health information to be used or disclosed under this authorization. If you wish to do so, please inform your clinician; (d) You may request in writing that we restrict how we use or disclose protected health information; (e) We must obtain a separate written authorization form you to disclose to any other party protected health information not listed in this consent; and (f) You have a right to receive a copy of this authorization if you so request.

Our *Notice of Privacy Practices* provides more detailed information about how we may use and disclosed protected health information about you. You have the right to review that *Notice* before signing this consent. We reserve the right to change the *Notice* in compliance with Federal and State statuses, and if we do so, you may obtain a copy of the revised *Notice* from the office manage at the address below.

I hereby authorize _____ and/or (name of other party) _____, to disclose my or my legal dependent's medical, psychiatric, and/or substance abuse records, and any and all information obtained in the course of my diagnosis and treatment to:

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_____	_____
Agency/Facility/Physician/School Name	Attention of

_____	_____	_____
Street Number and Name	City & State	Zip Code

_____	_____	_____
Telephone Number	Fax Number	E-mail

FOR THE FOLLOWING PURPOSES:

- Continuing care by the receiving provider
- Hospitalization/residential treatment
- Diagnosis/treatment
- Legal Proceeding/Advice
- Educational Planning/Academics
- Other (specify): _____

SUCH DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC INFORMATION:

- Psychological/psychiatric records
- Birth Records/history
- Psychological testing results & subtest scores
- Consultations
- Other (specify)_____

_____	_____
Date	Signature of Client
	_____
	Print Name
_____	_____
Date	Signature of Witness

_____
Name of Requesting Clinician