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Authorization to Release / Exchange Information

I,_____(hereinafter "patient") herby authorize Steven J. Covelluzzi, Psy.D. ("provider") to disclose/exchange mental health treatment information and records obtain in the course of my psychotherapy treatment, including, but not limited to Provider's diagnosis of me to:

Name:
Address:
Telephone:
Fax:

I understand that I have the right to receive a copy of this authorization. I understand any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

I am requesting this disclosure of information and records for the following purpose:

__ At the request of the individual

__ Other:_____

The specific uses and limitations of the types of health information to be released are as follows:

__ Treatment Coordination __ Treatment Planning __Diagnostic Refinement

__ Other:_____

Such Disclosure shall be limited to the following specific types of information:

__ Psychiatric Diagnosis(es) __ Dates of Treatment __ Treatment Summary

__ Initial Treatment Plan __ Full Treatment Record __ Other:_____

Provider shall not condition treatment upon patient signing this authorization and Patient has the right to refuse to sign this form.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule, although applicable California Law may protect such information.

This authorization shall remain valid until:_____(not to exceed one year)

_____

Patient's signature (Guardian(s) if minor) Printed Name Date