AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION

By completing this form, you are authorizing the disclosure and /or use of individually identifiable health information, as outlined below, consistent with California and Federal law provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Client Name:_____Date of Birth:_____

Frank Jay Jameson, M.A., L.M.F.T. is authorized to (*check all that apply*):

- ☐ Release or disclose records and /or information to
- ☐ Obtain or use records and/information from
- ☐ Mutually discuss and exchange records and/or information

This Information should only be released to: (Provide name or function of person(s) or organizations to whom the information is to be released).

_____

(Name of Person or Organization)

Specific Information to be Released/Obtained (*Please select only one*):

- ☐ All health/mental health information including diagnosis and treatment received.
- ☐ Only the following records or type of information:

_____

Please specify if any information is to be excluded:

_____

This disclosure of information authorized by Client is required for the following purpose:_____

_____

This authorization shall become effective immediately and expire in one year.

A photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and

may no longer be protected. California law prohibits pecipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law:

Your Rights:

- You may refuse to sign this Authorization
- You may revoke this Authorization only by delivering your revocation in writing to Frank Jay Jameson, M.A., L.M.F.T. Your revocation will be effective when your therapist receives it. Howver, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have a right to receive a copy of this Authorization.
- You ma inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

Signature of Client/Parent/Guardian: **Date:**

_____ _____

Your relationship to the Client:_____

To Revoke Authorizaion Only:

Authorization Revoked:___/___/___

_____

Signature of Client/Parent/Guardian