MARCIA HILLARY, PHD
Psychotherapy, Coaching
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AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION (HIPAA and CALIFORNIA LAW)

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 concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Client Name: _____ Date of Birth: _____

My therapist, *Marcia A. Hillary, PhD*, is authorized to: *(check all that apply)*

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

This Information should only be released to:

_____
Name or function of person(s) or organization(s) to whom the information is to be released

Specific Information to be Released/Obtained *(Select only one)*

___ All health/mental health information, including diagnosis and treatment received
___ Only the following records or type of information: _____

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 shall expire in one year.

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

Note: If you have authorized the disclosure of your Mental Health Information to someone who is not legally required to keep it confidential, that information may be redisclosed and may no longer be protected. California law prohibits recipients 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 *Marcia A. Hillary, PhD*. Your revocation will be effective when *Dr. Hillary* receives it. However, this revocation will not extend to information that was obtained or released (used or disclosed) prior to the revocation.

You have the right to receive a copy of this Authorization.

You may inspect or obtain a copy of your Mental Health Information, within the limits of California and federal laws.

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on your providing or refusing to provide this Authorization.

_____ _____

Signature of Client/Parent/Guardian Date

Your relationship to the Client: _____

To Revoke Authorization Only:

Authorization Revoked: _____/_____/_____

_____

Signature of Client/Parent/Guardian