

**Authorization to Disclose Protected Health Information**

I hereby authorize **Deborah Tucker, MA** ("Provider") to disclose to (name and/or function of the person or entity to whom disclosure is to be made) \_\_\_\_\_ ("Recipient")

the following protected health information:

- Entire File       Psychotherapy Notes       Session Start/Stop Times
- Diagnosis       Treatment Plan       Symptoms
- Prognosis       Progress to Date       Clinical Test Results
- Modalities & Frequencies of Treatment Furnished       Dates of Treatment
- Other \_\_\_\_\_

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it 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. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:

\_\_\_\_\_  
\_\_\_\_\_

The specific uses and limitations on the uses of my health information by Recipient are as follows: \_\_\_\_\_  
\_\_\_\_\_

I understand that Provider cannot condition treatment upon me signing this authorization.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

Provider is authorized to disclose the protected health information specifically listed above until: \_\_\_\_\_ (authorization expiration date).

By: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Patient's Representative\*)

\*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative: \_\_\_\_\_