AUTHORIZATION FOR RELEASE/REQUEST OF CONFIDENTIAL PATIENT INFORMATION/MEDICAL RECORD

Client's name _____ AKA _____
Case # _____ Birth Date_____SS#_____

I, the above-named client, hereby authorize, Phillip Lolonis, LCSW – 2223 Santa Clara Ave, Suite B5, Alameda CA 94501 510-748-0637

to disclose to: _____
(Specify medical doctor, physical therapist, school, job, referral source, etc.)

to receive from: _____
(Specify medical doctor, physical therapist, school, job, referral source, etc.)

the following information/record with the knowledge that it discloses information related to my mental and physical health as well as any court-related information.

This disclosure is for the purpose of coordination of treatment services and is limited to the following:

_____

This consent is subject to revocation at any time. It will expire automatically on _____ or upon the occurrence of the event described below:

_____

I understand that the person/organization receiving the above information, under Federal regulations and HIPPA, may not disclose this information further unless another authorization is obtained form me or unless such disclosure is specifically required or permitted by law.

Signature of Client _____ Date _____

Other person authorized to sign Denote relationship

_____

Print name and title of witness _____

Signature _____

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and HIPPA. The federal rules prohibit you from making any further disclosure of this information unless further is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any of the information to criminally investigate or prosecute any alcohol or drug abuse patient