BEACHSIDE THERAPY
& ASSESSMENT CENTER

CONFIDENTIAL – BEACHSIDE THERAPY & ASSESSMENT CENTER –RELEASE OF INFORMATION

AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION (HIPAA and California Law)

Beachside is a comprehensive therapy center. In order to give you the best care possible, it is important that we confer with other members of our team. Please sign this use and disclosure of mental health information so that we may consult together.

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.

Client Name:_____ Date of Birth:_____

(Therapist Name)_____is authorized to release or disclose

records to_____(name of doctor/psychiatrist/nurse practitioner) and mutually discuss and exchange records with the treatment team.

This information should **only** be released to Beachside Therapy Treatment Team and will include medical records and mental health records including diagnosis and treatment received.

Revocation of Authorization

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to _____ (therapist).

_____ _____
Signature of Client/Parent/Guardian Date

Your Relationship to the Client: _____

Your revocation will be effective when your therapist receives it. However, this revocation will not extend to information that was already 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.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

Date Authorization Revoked: _____

Signature: _____