Robert Reiser, Ph.D.
Licensed Psychologist (PSY 9327)
1036 Sir Francis Drake Blvd., Suite 13, Kentfield, CA 94904
Tel. (415) 297-1016 | robert.reiser@gmail.com

AUTHORIZATION TO EXCHANGE / RELEASE MENTAL HEALTH INFORMATION

Pursuant to HIPAA (45 C.F.R. § 164.508) and California CMIA (Cal. Civ. Code § 56.11)

SECTION 1: CLIENT IDENTIFICATION

Client Name (Last, First, Middle) ______ Date of Birth ______ Phone ______

Client Address ______

SECTION 2: AUTHORIZED PARTIES

I, ________________________________ (Client) and/or

________________________________ (Parent / Conservator)

authorize Robert Reiser, Ph.D. to exchange information with:

Contact Person / Clinician Name ______ Agency / Organization Name ______

Street Address ______ City ______ State ______ Zip Code ______

Telephone ______ Fax ______ Email ______

SECTION 3: DIRECTION OF INFORMATION EXCHANGE

Please check all that apply:

☐ **Release:** Dr. Reiser may disclose information listed below TO the party named above
☐ **Receive:** Dr. Reiser may receive information FROM the party named above
☐ **Both:** Dr. Reiser may both disclose to and receive information from the party named above

SECTION 4: PURPOSE OF DISCLOSURE

This authorization is made for the following specific purpose(s):

☐ **Evaluation and treatment planning / coordination of care**
☐ **Consultation with treating provider**
☐ **Legal or administrative proceeding**
☐ **Insurance / billing purposes**
☐ **Other:** ____

SECTION 5: SPECIFIC INFORMATION AUTHORIZED FOR DISCLOSURE

Initial only what you authorize. Information will be limited strictly to what is initialed below.

_____ Diagnosis

_____ Pertinent psychosocial assessment and psychiatric history

_____ Medical information including results of medical tests

_____ Results of psychological and vocational tests

_____ Legal status

_____ Educational assessment and behavior reports (including school and educational testing)

_____ Other: ______________________________

Note Regarding Psychotherapy Notes: Psychotherapy notes (process notes kept separate from the treatment record) are protected under a higher standard of confidentiality under HIPAA (45 C.F.R. § 164.508(a)(2)) and California law, and require a **separate written authorization**. This form does not authorize disclosure of psychotherapy notes. If you wish to authorize release of psychotherapy notes, please ask Dr. Reiser for the appropriate form.

SECTION 6: YOUR RIGHTS — PLEASE READ CAREFULLY

Right to Refuse: You have the right to refuse to sign this authorization. Signing is voluntary and is not a condition of receiving treatment from Dr. Reiser.

Right to Revoke: You may revoke this authorization at any time by providing written notice to Dr. Reiser. Revocation takes effect upon receipt and will not affect disclosures already made in reliance on this authorization.

Right to a Copy: You have the right to receive a copy of this signed authorization.

Re-Disclosure Warning (Required by HIPAA): Once your health information is disclosed to a person or entity outside of Dr. Reiser’s practice, federal privacy law (HIPAA) may no longer protect it from further re-disclosure by the recipient. You should consider this before authorizing disclosure.

SECTION 7: EXPIRATION

This authorization expires on: _______/_______/____________ (If left blank, this authorization remains in effect until revoked in writing.)

SIGNATURES

By signing below, I confirm that I have read this authorization, that my questions have been answered, and that I am signing voluntarily. I have received or been offered a copy of this signed form.

Signature of Client	Date
Printed Name of Client	

Signature of Parent or Conservator (if applicable)	Date	Relationship to Client

Signature of Robert Reiser, Ph.D.	Date

This form is governed by HIPAA (45 C.F.R. § 164.508) and the California Confidentiality of Medical Information Act (Cal. Civ. Code § 56.11). A signed copy must be retained in the client's record.