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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.