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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Name of Patient: _____,
hereby authorizes Linda Lewis Griffith, M.A., M.F.T., and

(Name of Clinician releasing information) _____

to exchange my health records and information obtained during the course of treatment.

The disclosure of such records authorized herein is required for the purpose of carrying out treatment, payment activities and/or healthcare operations.

Such disclosure shall be limited to the following specific information:

Such disclosure shall be limited for the following use of information:

The consent shall expire on _____

The Patient can request a copy of this authorization. The Patient has a right to refuse to sign this form. The Patient understands that information that is used or disclosed according to this authorization may be subject to re-disclosure by the recipient. The Provider will not make providing treatment a condition of signing this Authorization. The Patient is entitled to receive a copy of this form. For revocation of this form, the Patient must provide a written request to the clinician named above. California law may provide additional protection regarding the possible re-disclosure stated above.

Date

Client Signature (or Parent/Guardian)