Kathy Buratti, M.S., MFT
Licenced Marrige & Family Therapist
15300 Ventura Blvd., Ste. 324
Sherman Oaks, CA 91403
818-900-4535

AUTHORIZATION FOR EXCHANGE/RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, [Name of Client] _____

Date of Birth: _____

Address: _____

Hereby authorize [Name & Address of Provider]

_____

_____

to exchange/release/disclose confidential information obtained during the course of my treatment to [name and function of the person(s) or entities to which information is to be exchanged/released/disclosed with]

_____

_____

_____

INFORMATION TO BE EXCHANGED/RELEASED/DISCLOSED:

☐Any and All Information Necessary; ☐Diagnosis; ☐Treatment Plan;
☐Prognosis; ☐Progress to Date; ☐Clinical Test Results; ☐Dates of Treatment;
☐Patient Records; ☐Summary of Treatment;
☐Other: _____

PURPOSE OF EXCHANGE/RELEASE/DISCLOSURE: (Check applicable categories)

☐Client's Request: _____

☐Other (specify): _____

The recipient may use the information described above solely for the following purpose(s):

_____

_____

_____

I understand that by signing and authorizing the PHI exchange/release may not be further used or disclosed by the recipient unless such use of disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/ ____/ ____

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YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to receive a Copy of this Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Revoke This Authorization:** I understand that I have the right to revoke this Authorization at any time by telling Kathy Buratti, M.S., MFT in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to Kathy Buratti, M.S., MFT (see address above). I also understand that a revocation will not affect the ability of Kathy Buratti, M.S., MFT or any health care provider to use or disclose the health information for reasons related to the prior reliance of this Authorization.
Conditions: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of client/legal representative:

_____ Date: _____/ _____/ _____

Relationship to client: _____

Revocation of Authorization

Signature of client/legal representative:

_____ Date: _____/ _____/ _____

Relationship to client: _____