DEISY C BOSCAN, PHD., PSYCHOLOGIST, A PROFESSIONAL CORPORATION

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AUTHORIZATION FOR THE USE OF OR DISCLOSURE OF HEALTH INSURANCE
CLIENT AUTHORIZATION TO RELEASE CONFIDENTIAL PERSONAL HEALTH INFORMATION (PHI)

Confidentiality of Medical Information Act, California Civil Code section 56.11 and HIPPA

This authority includes oral and written communication and the furnishing of copies of clinical records.

NOTE TO ALL PATIENTS: Please print clearly and complete this form in its entirety. If the form is not completed in its entirety, your request will not be processed.

I,_____hereby, voluntarily authorize_____to release my Protected Health Insurance (PHI) concerning (please circle) myself, and/or my child or dependent obtained during treatment and/or evaluation, during the following period (dates of care) ___/____/_____through____/____/_____to the following:

1. Patient Information

Name: _____ DOB: ___/____/_____ Phone #: (____)_____

Address: _____City: _____ Zip Code: _____

2. Identify Person(s) or Organization(s) You Would Like to Receive Your Medical Information

Name:_____ Address: _____City: _____Zip Code: _____

Phone: _____ Fax: _____

This information will be limited to (Please **X** the selected information to be released):

_____Progress Notes _____Psychological/Educational Evaluations:

_____Progress Report(s) _____Other (Please specify) _____

LIMITATIONS AND LIABILITIES

This authorization is valid until____/_____/_____. No PHI can be released thereafter. I understand that I may revoke or modify this authorization, but must do so in writing to Dr. Boscán. I understand that this cannot change the fact that some PHI may have been sent or shared before this date. I also understand that:

a. I do not have to sign this authorization. My refusal to sign will not affect my abilities to obtain treatment.
b. I may inspect and have a copy of the PHI described in this authorization.

If the person or entity receiving my PHI is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I hereby release Dr. Boscán from any legal liability that may arise from my authorizing her to release this confidential information. I understand that I have a right to receive a copy of this information. I am affirming that everything in this form that was not clear has been explained, and I believe that I now understand all of it.

_____ _____ **Initial Here**

Signature of Client or Parent, or Personal Representative Date

_____

Describe Authority of Personal Representative