TERI M. POKRAJAC, PSY.D. & ASSOCIATES
A CLINICAL PSYCHOLOGY CORPORATION

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH INFORMATION (HIPPA)

Client Name _____ Date of Birth _____/_____/_____

My therapist, _____, is authorized to release and disclose

information to: _____
(name of person or organization)

(If applicable) _____ (name of person or organization) is authorized

to release and disclose information to: _____ (therapist's name).

Specific Information to be Released/Obtained (please select only one):

- § All health/mental health information including diagnosis and treatment received.
- § Only the following records or type of information: _____

Please specify if any information is to be excluded: _____

This disclosure of information authorized by _____ (client) is required for the

following purpose: _____

This authorization shall become effective on _____/_____/_____ and will expire in one year.

A photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

_____ _____
Client Date