Bay Area Marriage, Family & Child Counseling, Inc. **Form # 5**
39791 Paseo Padre Pkwy., Suite H
Fremont, CA 94538
(510) 612-6471

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ authorize _____

☐ to release information to: ☐ to receive information from:

_____
(individual , title, agency, or school)

_____ _____ _____
(address) *(city, state, zip)* *(area code & telephone)*

regarding _____ DOB:_____

I authorize the following information to be released:

☐ Any and all information necessary ☐ Treatment plan ☐ Prognosis
☐ Diagnosis ☐ Clinical test results ☐ Dates of treatment
☐ Patient records ☐ Summary of treatment
☐ Other: _____

for the purpose of (and limited to):

☐ Assessment and treatment ☐ Professional consultation ☐ Reimbursement
☐ _____

I understand that I am entitled to a copy of this form.
I understand that any cancellation or modification of this authorization must be in writing
I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I understand that such revocation must be in writing and received by Provider to be effective.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.
This Release shall be valid for one (1) year from the date below.

I have read and understand all of the terms and conditions above.

_____ _____ _____
(signature) *(relationship to client)* *(date)*

_____ _____ _____
(signature) *(relationship to client)* *(date)*

_____ _____ _____
(signature) *(relationship to client)* *(date)*

Signed: _____ _____
(Shalini Dayal) *(date)*

☐ copy to client ☐ client declined a copy

