

Authorization for Release of Health Records

I _____ (“Patient”) authorize Melissa Richman, Psy.D, LCSW A Psychotherapy Corporation and Licensed Clinical Social Worker (“Melissa Richman, Psy.D, LCSW”) to disclose information from my behavioral health records, which pertain to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and, or substance abuse diagnosis and treatment, as follows” :

The information is to be disclosed to:

Name: _____

Address (sender/receiver): _____

City, State, Zip _____

Contact Person: _____

Phone/Fax: _____

I authorize this information to be disclosed in all of the following ways:

- Written/Photocopy/Paper Electronic Format Verbal Fax Electronic Mail

The purpose of the disclosure is the furtherance of the Patient’s treatment, and to permit the Patient’s physician / clinician / family member / attorney / agent to know or monitor the Patient’s health status, and to coordinate and participate in all the care and /information which the Patient may receive from Melissa Richman, Psy.D, LCSW, and for the following additional reasons: _____

3. **Dates of Treatment:** From: _____ To: _____

Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released:

Please check the appropriate item(s):

- | | |
|--|---|
| <input type="checkbox"/> All of the Records listed | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Alcohol / Drug Assessments |
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Psychiatric Evaluations / Tests | <input type="checkbox"/> Alcohol / Drug Treatment Records |
| <input type="checkbox"/> Psychosocial Evaluations / Tests | <input type="checkbox"/> Other (Specify): _____ |
| <input type="checkbox"/> Psychological Testing Results | |
| <input type="checkbox"/> Entire Health Records (including information as may relate to my medical history, mental or physical condition or treatment of the same, including information relating to my mental health diagnosis or treatment and, or substance abuse diagnosis and treatment including, but not limited to, psychiatric / mental health treatment records, and information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.) | |

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Melissa Richman, Psy.D, LCSW in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or California privacy regulations.

Unless revoked earlier, this authorization expires one year after my treatment with Melissa Richman, Psy.D, LCSW has ended, unless I specify another time: _____

E-MAIL AND THE INTERNET MAY NOT BE RELIABLE, SECURE, OR PRIVATE. IF YOU WANT HEALTH INFORMATION TO BE SENT VIA EMAIL OR OVER THE INTERNET, PLEASE READ THE FOLLOWING INFORMATION ON THE RISKS OF RECEIVING EMAIL OR INTERNET COMMUNICATIONS. IF YOU REQUEST, EMAILS CAN BE ENCRYPTED. MY SERVER IS ALSO HIPAA PROTECTED.

RISKS OF USING E-MAIL / INTERNET to receive your health records:

- Messages can be hacked. (Unauthorized people can intercept it, alter it, or use it).
- Messages can be sent to the wrong person, lost, or subject to other sending errors.
- Messages may come from someone other than the named sender.
- E-mail is easier to fake than handwritten, signed papers.
- Anyone with access to the internet or an e-mail account will have access to all messages in that account. This includes those who have permission to use the e-mail account as well as those who don't.
- Anyone who gets or has access to an e-mail can read, forward, copy, delete, or change it. This includes those who have permission to use the e-mail account as well as those who don't.
- Any deleted e-mails can be found again.
- E-mail services have a right to save and check e-mail sent through their system.
- E-mail can spread viruses.
- The Internet is not completely secure.
- You should not receive your health information via the internet or email if people who you don't want to view your medical information have access to your email account or can hack your account.

If you are requesting that your information be sent to you or another person over the internet or by e-mail , you further acknowledge and agree to the risks of transmitting and receiving your information in this manner, and you agree to release and hold harmless Melissa Richman, Psy.D, LCSW from any liability that may result from using the internet or e-mail to communicate with you or another person you may have designated to receive messages that include your Health Information. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using the internet or e-mail (except as required by law).

I release Melissa Richman, Psy.D, LCSW from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient (or Patient Representative)

Date

Printed Name of Patient or Patient Representative

Authority of Representative to Act for Patient (Relationship to Patient)