KATIE VERNOY, LMFT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION:

I, _____, (relationship to client:_____) hereby authorize the use or disclosure of the following health information for:

Client Name:_____ Date of Birth: _____

Katharine Vernoy, LMFT is authorized to Use or Disclose the information AND/OR to Receive the information from:

Name:_____ Phone/Fax:_____

Address: _____

katievernoy@gmail.com ● www.katievernoy.com
(562) 646-7050 ● 23717 Hawthorne Blvd., Suite 205 ● Torrance, CA 90505
Katharine Vernoy, LMFT ● MFC42604

KATIE VERNOY, LMFT

The information will be used for the purpose of providing comprehensive mental health services and/or confirming participation in therapy and applies to the following information:
☐ All records including, but not limited to, medical history, psychiatric history, mental or physical condition and treatment received. [Optional] Except:

_____

_____

☐ Only the following types of health information or records (including any dates):

_____

_____

EXPIRATION: This authorization is valid until termination of services, or a period of one (1) year, whichever comes first.

This release expires on: _____

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RESTRICTIONS:
California law prohibits the provider from making further disclosures of the information, unless such disclosure is specifically required or permitted by law. Any additional written authorization must be obtained for a proposed new use of the information or for its transfer to another person or entity.

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed by that person and may no longer be protected.

YOUR RIGHTS:

1. I may refuse to sign this authorization.
2. I may revoke this Authorization at any time but understand that I must give my service provider a properly signed, written request.
3. My revocation will be effective when it is received by the service provider. However, this revocation will not extend to information that was already disclosed prior to the revocation.
4. I have the right to receive a copy of this Authorization.
5. I may inspect or obtain a copy of the health information being disclosed.
6. Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

KATIE VERNOY, LMFT

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature: _____ Date: _____

Signature of Parent/Legal Guardian/Legal representative:

_____ Date: _____

Print Name: _____

Relationship of Representative to client: _____

Witness Signature: _____ Date: _____

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