Authorization for the Release of Medical and Mental Health Information

Name _____ DOB _____ Phone _____

I authorize:

Danyale McCurdy-McKinnon, Ph.D.
250 East 1st St., Suite 300, Los Angeles, CA 90012
Phone: 405.757.5379
Email: danyale.mccurdy@gmail.com

To release medical and mental health information to:

Name _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

- ❑ **Check here if you consent to an exchange of information between the above parties**

Please specify the information you authorize to be released:

- ❑ Mental Health information (Subject to the Lanterman-Petris-Short Act, Welfare and Intuitions code § 5000 et seq.).
- ❑ Medical (This may include drug/alcohol and mental health information documented by a primary care practitioner).
- ❑ Drug and alcohol abuse, diagnosis, or treatment information created in a federal substance abuse facility (42 C.F.R. §§ 2.34 and 2.35).
- ❑ HIV/AIDS test results (Health and Safety Code § 120980 (g)).
- ❑ Other _____

Specify date(s) of treatment, if applicable: _____
Limitations upon disclosure: _____

_____

_____

The purpose of this release is:

- ❑ At the request of the client/patient/representative

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this Authorization expires on. If no date is indicated, the Authorization will expire upon termination of my treatment with Danyale McCurdy-McKinnon, Ph.D.

_____
Client/Patient/Representative Signature

_____
Print Name Relationship to Client

Date _____

NOTICE: Dr. McCurdy-McKinnon and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect your health information.

YOUR RIGHTS: The Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, and/or (4) solely to create health information to provide a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your client/patient representative, and delivered to Dr. McCurdy-McKinnon. The revocation will take effect when Dr. McCurdy-McKinnon receives it, except to the extent that Dr. McCurdy-McKinnon and others have already relied on it. You are entitled to receive a copy of the Authorization.