Sheri Rose-McCashin M.S., LMFT 28036
12381 Wilshire Blvd., Ste., 200
Los Angeles, CA 90025
sherirrose@gmail.com
310-490-2130

AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION (HIPAA and California Law)

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. All information requested must be provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Client Name: _____Date of Birth: _____

My therapist, Sheri Rose-McCashin, LMFT 28036.

- ☐ Release or disclose records and/or information to
- ☐ Obtain or use records and/or information from
- ☐ Mutually discuss and exchange records and/or information

This Information should only be released to: (Provide name or function of person(s) or organizations to whom the information is to be released).

_____
(Name of Person or Organization)

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

☐ All health/mental health and legal 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 immediately and 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 re-disclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.*

Your Rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to Sheri Rose-McCashin (your therapist). Your revocation will be effective when your therapist receives it. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

_____ _____

Signature of Client/Parent/Guardian: **Date:**

_____

Your Relationship to the Client:

To Revoke Authorization Only:

Authorization Revoked: ___/___/___

_____

Signature of Client/Parent/Guardian