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**AUTHORIZATION TO DISCLOSE INFORMATION**

**Completion of this form authorizes the use and disclosure of confidential or protected health information about you to third parties. All information requested must be completed for the authorization to take effect.**

**Client Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize Dr. Tangen to disclose medical information obtained during the course of service. This information is to be disclosed to the name(s) or function(s) of the person(s) or entity(ies) designated in the box below at the following point(s) of contact (note: address, fax, email or phone number):

**I understand that:**

- This authorization is voluntary and is not a condition of receiving treatment.
- I have a right to receive a copy of this authorization.
- A modification or revocation of this authorization may be made at any time.
- The modification or revocation must be made in writing with signature.
- The modification or revocation will take effect upon receipt and is not retroactive.

**Type of disclosure:**

verbal information  copies of records  letter  proof of attendance  summary report  other: \_\_\_\_\_

**Purpose of disclosure:**

mental health care  insurance application  legal issue  disability determination  vocational rehabilitation  other: \_\_\_\_\_

**Information to be released:**

entire record  diagnosis or condition  records for the following treatment dates: \_\_\_\_\_  other: \_\_\_\_\_

**The following restrictions are placed on the disclosure:**

none  specify: \_\_\_\_\_

**Unless otherwise revoked, this authorization will remain valid until:**

the following date: \_\_\_\_\_  the happening of the following event: \_\_\_\_\_

If no date is indicated, the authorization will expire 12 months after the date of signature on this form.

I understand that the medical information to be used or disclosed is protected by law and that the use or disclosure pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law. However, California law prohibits the person or entity receiving my health information from making further disclosure unless another authorization for such disclosure is obtained from me or such disclosure is specifically required or permitted by law.

I further understand this authorization will conform to my directives as described in this form.

\_\_\_\_\_  
**Client (or Personal Representative) Signature & Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship to Client (if other than Client)**