AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individuals health information as described below.

CLIENT: _____ DATE: _____

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE:	SS#:	DATE OF BIRTH:
AKA'S:		

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE

LAST NAME OR ENTITY: **TRUE NORTH PSYCHOLOGICAL SERVICES, INC**		
ADDRESS: **3355 MISSION AVE, STE 111**	CITY/STATE: **OCEANSIDE, CA**	ZIP CODE: **92058**
TELEPHONE:	DATE:	

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION

LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE:	☐ AT THE REQUEST OF THE INDIVIDUAL	DATE:
TREATMENT DATES:	PURPOSE OF REQUEST:	

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

☐ PSYCHOLOGICAL EVALUATION	☐ MEDICATION REPORTS	☐ IMMUNIZATION RECORDS
☐ DISCHARGE SUMMARY	☐ PHYSICIAN ORDERS	☐ NURSING NOTES
☐ PROGRESS NOTES	☐ PHARMACY RECORDS	☐ BILLING RECORDS
☐ LABORATORY RESULTS	☐ DRUG/ALCOHOL REHABILITATION RECORDS	☐ PSYCHIATRIC RECORDS
☐ DIAGNOSIS	☐ COMPLETE RECORD	☐ OTHER (DESCRIPTION)

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, aquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I do not specify an expiration date, event or condition, this authorization will expire in one calender year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information, except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, please note, we are unable to forward your information to anyone without your consent. Should you need records transfered in the future, a report written (for active duty, bariatric pre-surgery, post-accident, etc), we will need this release signed in order to do so & further appointments & treatment could be delayed as a result.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.
I would like a copy of this authorization. ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:
IF SIGNED BY A LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE ONLY

VALIDATE IDENTIFICATION

SIGNATURE OF STAFF:	DATE:

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