Sacramento
CENTER FOR PSYCHOTHERAPY

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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH INFORMATION

I, Patient Name(s)_____Date of Birth_____
give permission to Martha Gilmore, Ph.D./Haim Weinberg Ph.D (circle one)
to: _____ release, _____ exchange, _____receive (initial one or more)
with: Name _____Phone _____
Address _____

Specific Information to be Released/Obtained (initial only one):
___All health/mental health information including diagnosis and treatment received.
___ Only the following type of information: _____

This disclosure of information authorized by Patient is required for the following purpose:
_____

This authorization shall become effective on ____/____/____ and will expire in one year or treatment termination, whichever is longer.
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 redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing 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 Haim Weinberg, Ph.D./Martha Gilmore, Ph.D. 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 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 Patient/Parent/Guardian/Conservator: Date:

_____

Your Relationship to the Patient:_____