Michael J. Smith, Psy.D. PSY20563

1304 Castro Street, Suite B Street San Francisco, CA 94114 415-310-8873

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ ,(hereinafter "Patient") hereby authorize Michael J. Smith, Psy.D. (hereinafter "Provider") to **Release to** or **Receive from**:

_____

Name of Facility/Individual Receiving/Releasing Information

_____

Address

_____

Information obtained in the course of my diagnosis and treatment for the purpose of _____ and shall be limited to the following types of information:

__ Discharge Summary
__ Assessment
__ Annual Plan of Care
__ Other (specify) _____
__ Results of Psychological Testing
__ Substance Abuse Treatment
__ Physician's Orders

MY Rights: I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **1304 Castro Street, Suite B, San Francisco, CA 94114** to be effective.

Provider shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Patient Signature: _____ Date: ____/____/____