Associated Therapists, Inc.
Disclosure of Health Information Authorization

I. I hereby authorize Associated Therapists, Inc. and its professional staff, the use or disclosure of my protected health information as described below and understand and acknowledge the following:

1. I am not required to sign this authorization and may in fact refuse to sign this authorization.
2. Associated Therapists, Inc. will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
3. If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
4. I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
5. I have the right to revoke this authorization at any time.
6. My revocation must be in writing and submitted to Associated Therapists, Inc. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
7. If I have any questions about this authorization, I may contact Patricia Taylor at (714) 898-0362, who will provide me with more information about this authorization, or about Associated Therapists, Inc.'s privacy practices.
8. If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected health information.

II. Patient Name: _____ Soc. Sec #: _____

Address: _____ City, State, Zip: _____

III. This authorization applies to the specific information set forth below:

_____

IV. The following persons or organizations are authorized to receive my protected health information identified above:

Name: _____ Voice Phone: _____

Address: _____ Fax Number: _____

City, State, Zip: _____

V. This authorized use or disclosure is for the following specific purpose(s):

_____

VI. This authorization will expire on ____/____/_____ (dd/mm/yr); or upon the following event:

_____

I certify that I have read, signed and know that I have a right to receive a copy of this authorization.

Signature of Patient (or personal representative): _____ Date: _____

Personal Representative's Name: _____

Relationship of Patient Representative to Patient: _____