Claire James, Ph.D.
Psychologist, PSY 24585
590 Searls Ave. #5, Nevada City, CA 95959
Business: 530-265-4470 Fax: 530-264-7527

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name:_____
Date of Birth:_____

Consistent with California and Federal Law I authorize the disclosure and/or use of my Protected Health Information (PHI) as described below:

____ Claire James, Ph.D. is authorized to release my PHI to:
Name:_____
Address:_____
Phone:_____ Fax:_____

____ Person/entity below is authorized to release PHI to Claire James, Ph.D.
Name:_____
Address:_____
Phone:_____ Fax:_____

Description of PHI to be released:
____ All health information pertaining to medical history, mental or physical condition, and treatment received
____ Mental Health Treatment Information
____ Alcohol/Drug Treatment Information
____ HIV/AIDS test results
____ Other:_____

Purpose of PHI Disclosure:
____ Evaluation/Diagnosis
____ Treatment/Treatment Planning
____ Consultation
____ Other:_____

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This authorization shall remain valid until:_____

My Rights as a Patient:

I have a right to receive a copy of this authorization. I have a right to revoke this authorization at any time. The revocation of this authorization will be effective upon written receipt except when action has been taken in reliance on this authorization. This authorization will be placed in my file.

I understand that any cancellation or modification of this authorization must be in writing to be effective and received by Claire James, PhD at 825 Zion St., Nevada City, CA 95959.

I have the right to refuse to sign this form and my health treatment or fees will not be conditioned upon whether or not I sign this authorization.

Information disclosed pursuant to this authorization to a party not required to keep it confidential may be subject to re-disclosure and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

_____

Patient's Signature Date

_____

Patient's Representative Signature Date
(Parent, Guardian, Conservator)

If signed by someone other than the patient, state your legal relationship to the patient and your authority to act on her or his behalf.

_____