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CONSENT TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I, _____ (Client) and/or (Parent / Legal Guardian) _____

Authorize (Releasing Agency / Physician / Person): _____

to disclose to **Devora Weinapple, MFT, Lic. #81558, ATR-BC**, (Receiving Agency or Provider) the following information with the knowledge such release discloses the fact that the named person has received mental health services.

This disclosure shall be limited to the following specific information:

____ Diagnosis, medical information, and results of medical tests

____ Summary of psychological and psychiatric History

____ Results of psychological and vocational tests ____ Legal status

____ Educational assessment and behavioral reports (*including school observation and educational testing*)

____ Other _____

This disclosure of the above-mentioned specific mental health information is required for evaluation or treatment or for the following purpose (indicate any other purpose and use of this disclosure):

I understand that: 1) My mental health records are protected under the California Welfare and Institutions Code (WIC) and the federal *Health Insurance Portability and Accountability Act (HIPAA)* of 1996, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. The exceptions are set forth in the Notice of Privacy Practices, 2) I may revoke my consent by providing written notice withdrawing my consent, and 3) If the program has already disclosed information in reliance on my consent, the program is not required to try to retrieve that information.

I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. If not earlier revoked, this consent shall automatically terminate and expire on or as follows: (*give date, event or condition, upon which this consent expires*):

By: _____

CLIENT SIGNATURE (18 or older)

Date: _____

By: _____

PARENT / LEGAL GUARDIAN / CONSERVATOR SIGNATURE

Date: _____

Provider: _____

Credentials: _____

Date: _____