Dr. Gia Marson
Psychologist
Malibu | Santa Monica

310-526-3123
www.drgiamarson.com
General inquiries: info@drgiamarson.com

Release of Information: Authorization for Use and Disclosure of Confidential Information (HIPAA and CA Law)

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with the CA Law and Federal Law concerning privacy of such information. All information must be provided for this authorization to be valid.
Use and Disclosure of Health/Mental Health Information

Client's name ____ Date of birth _________________

My therapist, Dr. Gia Marson is authorized to (check all that apply)
__________ Release or disclose records and/or information to
__________ Obtain or use records and/or information from
__________ Mutually discuss and exchange records and/or information

This information should only be released to:
____
____

Contact this provider/entity by telephone at: ____
or by email at: ____

Specific Information to be Released/Obtained (Please select only one)

__________ All health/mental health information including diagnosis and treatment received

__________ Only the following records or type of information
____

Please specify if any information is to be excluded:
____

This disclosure of information authorized by Client is required for the following purpose
____
____

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This authorization shall become effective immediately and expire in one year. A copy or fax is considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health/health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. CA 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 by delivering your revocation in writing to me at my office (see address above). However, this revocation will be effective when I receive it and will not extend back to information that was already obtained or released (used or disclosed) prior to the revocation.
You have a right to receive a copy of this authorization.
You may inspect or obtain a copy of your mental health information within the limits of CA and federal laws.
Neither treatment, payment, enrollment or eligibility for benefits will be conditioned upon your providing or refusing to provide this authorization,

I have read and understand the information provided above. I have discussed it with Dr, Marson, and all of my questions have been answered to my satisfaction. If signed by anyone other than the client, please indicate your relationship.

Name: ____ Date______________________

Signature ____

*If you are under 18yo, please have your parent/guardian/conservator complete this portion below to consent

Name: __________________________________ Relationship ____________________________

Signature ____

If you no longer wish to authorize this release of information, please complete the portion below and bring it to me at our next appt. I am hereby revoking this authorization:

Name: ____ *Date of revocation* __________

Signature ____