

**Dr. Gia Marson**  
**Psychologist**  
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**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: (Provide name or function of the person(s) or organization to whom information is to be released) \_\_\_\_\_

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**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: \_\_\_\_\_

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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,

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Signature of Parent/Guardian if Minor Client

\_\_\_\_\_  
Date of Authorization

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**To revoke authorization only:**

Date of revocation \_\_\_\_\_

Signature of Client (or parent or guardian) \_\_\_\_\_