Timothy D. Stein, MFT ♦ 1101 College Avenue, Suite 230 ♦ Santa Rosa, CA 95404 ♦ (707) 888-9098 ♦ www.TimSteinMFT.com

Authorization to Release Protected Health Information

I hereby authorize Timothy D. Stein, MFT to

☐ disclose

☐ exchange

protected health information with: _____
Name

_____
Mailing Address

_____
City, State, Zip Code

_____
Phone

Type of disclosure and/or exchange:

☐ Verbal ☐ Copies of Records ☐ Letter ☐ Proof of Attendance

☐ Other _____

I authorize the disclosure of protected health information for the following purposes:

_____

The specific uses and limitations of my protected health information by Recipient are as follows:_____

I understand that Timothy D. Stein, MFT cannot condition treatment upon me signing this authorization.

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Timothy D. Stein, MFT has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Timothy D. Stein, MFT to be effective.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

This authorization shall remain valid until: _____
Authorization Expiration Date

_____ _____ _____
Signature of Client/Legal Guardian | Client/Legal Guardian Name (Print) | Date

If signed by Legal Guardian, client name: _____