Irma Rivera-Carlisle, MDiv, MA, MFT
Rivercar2@yahoo.com
Irmarivera-carlislemft.com

Authorization to Disclose Protected Health Information

I hereby authorize **Irma Rivera-Carlisle, MFT** to disclose to _____
(**Name of Provider**)

_____
(Address)

_____/_____/_____
Phone # Cell # Fax #

The following protected health information:

____ Diagnosis ____ Progress to Date ___ Dates of Treatment ____ Other

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 Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

I authorize the disclosure of the health information described above for the following purpose:

_____

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

_____

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 redisclosure of such information may be protected by applicable California law.

Provider is authorized to disclose the protected health information until: _____ (Expiration date)

By: _____ Date: _____
Client's Signature

Client Name: (Please Print) _____

• **Provider Signature**: _____