Authorization to Release Protected Health Information

I, _____ (client or guardian name), authorize

Katherine M. Newhouse, LMFT and **(please provide other party's details)**

Name _____

Address_____

Phone _____**Fax**_____

to disclose protected health information about clinical care regarding (Client's name & date of birth)

_____

Type of disclosure and/or exchange:_____

The specific uses and limitations of this protected health information are:_____

I understand that Katherine M. Newhouse, LMFT 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 Katherine M. Newhouse, LMFT has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Katherine M. Newhouse, LMFT 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 6 months from the time it is dated unless another date is specified:_____

_____
Signature of Client/Legal Guardian and date

_____
Printed Name of Client/Legal Guardian and date

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