Authorization for the Release or Obtain Confidential Information

Client's Name: Date of Birth:

I, (fill in name) _____ authorize use or disclosure of protected health information between Donka Le-Dimitrova, MA. LMFT and the following individual/ organization:

Name of individual/organization: _____
Email address: _____
Address:_____ Phone: _____

The specific information that should be disclosed is (please check boxes for information you request to share):

- ☐ Diagnosis
- ☐ Medical, Educational and/or Psychological/ Psychiatric Assessment
- ☐ Treatment or Client Plan
- ☐ Individualized Family Service Plan (IFSP)
- ☐ Individualized Education Plan (IEP)
- ☐ Individual Program Plan (IPP)
- ☐ Behavioral Treatment Information
- ☐ Other_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *_____

NO, DO NOT DISCLOSE THIS INFORMATION * _____

This authorization is valid for one (1) year from the date of signature, unless revoked or a

different date is specified here: _____/_____/_____. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Donka Le-Dimitrova, MA, LMFT in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

_____Parent/Guardian Signature/Date