Eleanor Castillo Sumi, Ph.D., Licensed Psychologist PSY 17407

Authorization To Release & Exchange Confidential Information

Child:	DOB:

I, _____ authorize Dr. Eleanor Castillo, Licensed Psychologist PSY 17407, to receive, release / disclose and/or exchange the following information with:

_____	_____	_____
Name of Agency / Party	Phone Number	Fax Number

_____

Mailing Address of Agency / Party

For the purpose of : _____

(Records will not be disclosed without a valid reason listed above)

Disclosures shall be limited to the following specific information:

	Diagnosis/es		Results of psychological test
	Educational test		Functional Behavior Assessment and/or other behavioral reports
	Medical Information		Summary of psychosocial & psychiatric history
	Legal Status		Dates of Service:
	Other:		Other:

A copy of this release has been: provided_____ was declined_____

_____ _____

Signature Date

_____ _____

Eleanor D. Castillo, Ph.D., Licensed Psychologist, PSY17407 Date

I authorize Dr. Eleanor Castillo to receive, release / disclose and/ or exchange the following information noted on above with knowledge such release discloses the name of the client receiving mental health services.

I understand that the information to be disclosed is of psychological nature and is protected under the Lanterman Petris Short Act (CA, Welfare & Institutions Code Section 5000 et seq., 1999) and the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, and can not be re-released to any other entity or individual without my additional signed consent unless otherwise provided by the regulations. However, in contradiction the Federal HIPAA Privacy Regulation, Text 45, CFR legislation, 2002, requires care providers to inform each client that his or her protected health information may be re-disclosed by other entities or individuals.

As set forth in the Notice of Privacy Practices, I understand that I may withdraw this authorization at any time. If not revoked, this Authorization will be valid and include release/exchange of information for up to **1 year** from signature date or until discharge date (whichever comes first).

I also understand that I have the right to receive treatment even if I choose **NOT** to allow my records to be released.