William Curci, Ph.D.
Licensed Clinical Psychologist, PSY 31171

Hillcrest Office	**Solana Beach Office**	**Correspondence**
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AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH TREATMENT INFORMATION

I, _____, whose Date of Birth is _____, authorize William Curci, Ph.D.

to disclose to and/or obtain from:

_____ the following information:

Description of Information to be Disclosed (initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Nursing/Medical Information
_____ Progress in Treatment
_____ Demographic Information
_____Other:_____
_____

Purpose:

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:

_____

_____

Revocation:

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to William Curci, Ph.D. at 6965 El Camino Real Ste 105 #170, Carlsbad, CA. 92009. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Form of Disclosure:

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure:

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date