Feel Better Counseling
Kathleen Jeanne Troncao-Heath; Licensed Marriage & Family Therapist; LMFT#77993

Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____State: _____

Zip: _____ Phone: _____

I request that my protected health information (PHI) from [healthcare provider] be disclosed to:

Jeanne Troncao-Heath, MS, LMFT; dba Feel Better Counseling

2217 F Street, Suite E, Bakersfield, CA 93301

Email: info@feelbetterbakersfield.com **Phone:** 661-383-0378 **Fax:** 661-489-1888

I authorize the following PHI to be released from my medical record(s):

__ Entire Record __ Treatment Progress __ Diagnosis __Test Results __ Dates of Treatment

__Session Start/Stop Times __ Treatment Plan or Goals __ Prognosis

__ Other (please specify):

_____

Covering the period of healthcare from: _____to _____

Purpose for disclosure of information:

_____

Disclosure Format (Paper is default if not marked): _____US Mail (paper format)

Fax _____

E-mail (secure format) _____ _____

By signing this authorization form, I understand that: • Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law. • I have the right to **REVOKE** this authorization at any time. Revocation must be made in writing and presented or mailed to Jeanne at Feel Better Counseling; 2217 F Street, Suite E; Bakersfield, CA 93301. Revocation will not apply to information that has already been disclosed in response to this authorization. • **Unless otherwise revoked, this authorization will EXPIRE on the following date/event/condition:**

_____

If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from date signed.

• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. • Any disclosure of information carries with it the potential for unauthorized redisclosure.

• I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the
original.

_____ _____

_____ _____

Signature Date Signature Date

_____ _____

_____

Print Name Print Name