REBECCA WURZBURGER, PSYD
Clinical Psychology
PSY24899

AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION

Use and disclosure of Mental Health Information:

Client Name: _____ Date of Birth: _____

Rebecca Wurzburger PsyD is authorized to (circle all that apply):

- ■ Release or disclose records and /or information to: _____
- ■ Obtain or use records and/or information from: _____
- ■ Mutually discuss and exchange records and/or information with: _____

This information should only be released to: _____

Specific Information to be Released/Obtained (circle one):

- ■ All health/mental health information including diagnosis and treatment received.
- ■ Only the following records or types of information: _____

Please specify of any information is to be excluded:_____

This disclosure of information authorized by client is required for the following purposes:

_____

_____

This authorization shall become effective immediately and expire in one year and a photocopy or facsimile of this form is to be considered as valid as the original.

Your Rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to Rebecca Wurzburger PsyD. Your revocation will be effective when Rebecca Wurzburger receives it. However this revocation will not extend to information that was already obtained or released (used or disclosed) prior to this revocation.
- You have a right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

Signature of Client/Parent/Guardian:_____ Date: _____

Your Relationship to the Client: _____