# Cathy Goldfarb, Psy. D., LCSW

## Authorization for Release of Protected Health Information

Name of Persons/Organization and Contact Information with whom I may (please indicate the manner in which I may contact):
Confer-(  ); Receive only-(  ); or Send only-(  )

_____

_____

_____

_____

I request that the health information to be released consist of the following:
(Please mark the items you authorize me to release.
Do NOT mark the items you do NOT authorize me to release)

_____Billing Statements
_____Drug and Alcohol Abuse Information
_____HIV/AIDS treatment Information
____Psychological/Vocational
____Test Results
____Consultations and Evals
____Discharge Summaries
_____Other-Please Specify_____

I hereby authorize Cathy Goldfarb, Psy.D, LCSW to use or disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I am not required to sign this form. I understand that I may be provided with a copy of this form if I choose to sign it. I understand that my treatment, payment or eligibility of benefits will not be affected by my decision to sign this form. I understand that I may request to see and receive a copy of the information described on this form. I understand that I may revoke this authorization at any time by notifying me in writing.

I understand that this authorization is valid until_____, or revoked in writing.

Authorized Signature_____

Patient Name (Please Print)_____Date:_____

Name of Legal Guardian/Parent (if patient is a minor)_____

**3231 Ocean Park Blvd., Suite 204 Santa Monica, CA  90405 | (310) 201-6352**