AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH TREATMENT INFORMATION

I _____ , whose date of birth is _____,
authorize Catherine Cassel, MSW, LCSW to disclose to and/or obtain from:

_____

information regarding my psychotherapy assessment, diagnosis and treatment for the following purpose:

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to:

Catherine Cassel, LCSW
P.O. Box #218
Berkeley, CA. 94701

Expiration

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

Conditions

I further understand that Catherine Cassel, MSW, LCSW will not condition my treatment on whether I give authorization for the requested disclosure.

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 not 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 Client Date

_____

Catherine Cassel, MSW, LCSW Date