OFFICE AND PRACTICE OF J. BERNARD CORDOBA, MD

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I specifically authorize Dr. Cordoba or designated employee(s) to disclose my Protected Health Information as described on this form to the recipient listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

* Description of the information to be used or disclosed *(check all that apply):*

[ ] My entire mental health record and all the information below (meaning everything, including psychotherapy notes)

(NOTE: This requires an explanation of why it is necessary to disclose the entire record)

_____

_____

[ ] My demographic information *(check all that apply):*

[ ] Name [ ] Address [ ] State/Zip code only [ ] Telephone

[ ] Age [ ] Gender [ ] Race [ ] Other

[ ] Only Mental health information as related to:

[ ] Specific condition(s):_____

[ ] Specific professional service(s):_____

[ ] Specific medication(s):_____

[ ] Other:_____

[ ] Only Psychotherapy Notes

[ ] Other:_____

**Please disclose the above information to:*

Name:_____ Telephone/Fax: _____

Address:_____

* Purpose(s) for the disclosure of the information:

_____

_____

This authorization is effective upon signature and remains effective until it's revoked. I have the right to revoke this authorization in writing, although I understand that action may have already been taken in reliance on this authorization prior to Dr. Cordoba receiving the revocation. In order for the revocation of this authorization to be effective, Dr. Cordoba must receive the revocation in writing and the revocation must include:

- My name, address and patient number, if applicable
- The effective date of this authorization and the recipients of the Protected Health Information according to this authorization
- My desire to revoke this authorization
- The date of the revocation and my signature

I will pay for all reasonable costs for copying, postage and preparation this information.

I fully understand and accept the terms of this authorization.

_____ _____

Patient's Name Date

_____

Patient or Patient's Representative Signature

_____ _____

Name of Representative (if applicable) Description of authority to act for Patient

*_____

Patients Initials

Patient requests to fax this information to another facility or physician's office and is aware of confidentiality risks involved and releases Dr. Cordoba from such risks.

For Office Use Only

[ ] Authorization added to the client's chart on _____

[ ] Client has been provided with a copy of the signed authorization