Michelle A. G. Witkin, Ph.D.
Licensed Psychologist #PSY14855
28494 Westinghouse Place, Suite 203, Valencia, CA 91355
661-753-3987

AUTHORIZATION FOR USE/DISCLOSURE OF MENTAL HEALTH INFORMATION

By completing this form, you are authorizing the disclosure and/or used of individually identifiable health information as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

Use and disclosure or Mental Health Information:

Patient Name: ____

Date of Birth: ______________________________________
****
Michelle Witkin, Ph.D. is authorized to (*check all that apply)*:

□ Release (i.e., "Disclose") information to
□ Obtain (i.e., "Use") information from

____ at (telephone #):_____________________________________
(Name of Person or Organization)
and (address): ____
****

In addition, ____ is authorized to (*check all that apply)*
(Name of Person or Organization)

□ Release (i.e., "Disclose") information to
□ Obtain (i.e., "Use") information from

Michelle Witkin, Ph.D.
****
The information will be used for the purpose of assisting in diagnosis and/or treatment planning for the above named patient (*If applicable, specify other purposes the information will be used for)*____________________
____

Specific Information to be Released/Obtained (*Please select all that apply):*

□ **All records** including, but not limited to, medical history, psychiatric history, mental or physical condition and treatment received. (OPTIONAL) Except:
____
____

□ **Only the following types of health information or records (including any dates):**
____
____

Please specify if any information is to be excluded: ____

This authorization shall become effective ___/___/___ . It expires one year from the effective date of at the end of treatment, whichever comes sooner.

California law prohibits Dr. Witkin from making further disclosures of the specified information to any person or entity not specified herein, unless such disclosure is specifically required or permitted by law. An additional written authorization must be obtained for a proposed new use of the information or for its transfer to another person or entity. Please note: If you have authorized the disclosure of your mental health information to someonw who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this Authorization
- You may revoke this Authorization at any time by signing the area below. You may also revoke this Authorization by delivering your revocation in writing (and signed by yourself and on your behalf) to Dr. Witkin in person at her office or by mail at 28494 Westinghouse Place, Suite 203, Valencia, CA 91355. Your revocation will be effective when it is received by Dr. Witkin. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation..
- You have a right to receive a copy of this Authorization. You must receive a copy if Dr. Witkin will be using or disclosing your information.
- You may inspect or obtain a copy of the mental health information that you are being asked to be used or disclosed, within the limits of the laws pertaining to confidentiality of mental health information for minors.
- ** Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this authorization (see note below for exceptions).

Signature of Patient/Parent/Guardian/Conservator: ____

Your Relationship to the Patient: ____

Witness: ____

Date: ________________________ Time: __________________________ AM/PM

** This does not apply if Dr. Witkin is seeking to use the information in any of the following ways: (1) to conduct research-related treatment, (2) to obtain information in connection with your eligibility or enrollment in a health plan of which you are not already a member, (3) to enable Dr. Witkin to determine obligation to pay a claim, or (4) to create health information to provide to a third party. Under no circumstances, however, are you required to authorize the disclosure or psychotherapy notes (private notes which may be held by a psychotherapist and are not part of your [your child's] client record).
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To Revoke Authorization Only:

Authorization Revoked: ____/____/____ ____

Signature of Patient/Parent/Guardian/Conservator