CONSENT FOR USE, DISCLOSURE AND/OR RELEASE OF PERSONAL AND HEALTH INFORMATION

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH

ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER

I. PERSON OR AGENCY *REQUESTING* THE INFORMATION:

The persons or agency can request my personal, health, and/or mental health information: (The information to be released is described in Section III below.)

Agency Name: **Kimberly Warner-Getskow**

Address: **25050 Peachland Avenue Suite 250**

City, State, Zip Code: **Santa Clarita, CA 91321**

Agency Contact and Title: **Kimberly Warner-Getskow LMFT**

Telephone No.: **661-367-1006**

II. PERSON OR AGENCY *PROVIDING* THE INFORMATION:

The persons or agency may release my child's personal, health, and/or education information: (The information to be released is described in Section III below.)

Agency Name:

Address:

City, State, Zip Code:

Agency Contact and Title:

Telephone No.:

III. INFORMATION THAT MAY BE RELEASED:

The persons or agencies marked in Section IV below may view, copy, release and exchange the information or records marked below *(please check all that apply to your needs now and in the future)*. This information may be shared verbally, in writing, and/or by email or fax:

- ☒ Mental Health Information, including but not limited to operative, emergency, radiology, consultations, progress notes.
- ☐ Family Information, including but not limited to size of family, family income, family support.
- ☐ Developmental Information
- ☐ Educational Records
- ☐ Speech/Language Information
- ☐ Developmental Screening Information
- ☐ Other:
- ☐ Other:

SPECIFIC AUTHORIZATIONS:

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☒ I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code, §§5328, et seq)

IV. INFORMATION MAY BE EXCHANGED BY THE FOLLOWING PERSONS OR AGENCY(IES):

I know that the service team includes the persons and/or agencies marked below *(Please check all that apply to your needs now and in the future.)*:

☒ Mental Health Services
- ☒ Psychologist
- ☒ Physician/Psychiatrist
- ☒ Therapist
- ☒ Social Worker
- ☒ Case Manager
- ☐ Other ____________

☐ School District (specify:___________)
- ☐ Teacher
- ☐ School Psychologist
- ☐ School Counselor
- ☐ School Administrator
- ☐ Speech/Language Therapist
- ☐ School Nurse
- ☐ Other:_________

☐ Social Services Agency
- ☐ Social Worker
- ☐ Case Manager
- ☐ Other:__________

☐ Healthcare Services
- ☐ Primary Health Care Provider
- ☐ Physician Specialist
- ☐ Social Worker
- ☐ Psychologist
- ☐ Family Support Worker
- ☐ Other:_________

☐ Regional Centers
- ☐ Service Coordinator
- ☐ Administrative Staff
- ☐ Family Support Worker

☐ Family Resource Center
- ☐ Case Manager
- ☐ Administrative Staff
- ☐ Family Support Worker

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form, and it will not affect the services I receive from any of the agencies.

LENGTH OF TIME: This consent will be valid from the date that I sign this form until _____________(date). If no date is entered, the form will be valid for one year after the date that I sign the form.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency(ies) in Sections I and II. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one.

Signature:	Date:
Printed Name:	Relationship to patient: