This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et seq., of the California Civil Code.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of patient

I hereby authorize the use, disclosure or request of my health information as follows:

Organization authorized to use or disclose the information:

Rosita Cortizo Psy.D, MFT, MA

(619) 920-1638

Private Practice

Persons or organization authorized to receive the information:

Community Health Group/ George Scolari

740 Bay Blvd., Chula Vista, CA 91910

Tel: (800) 404-3332 Fax: (877) 862-7603

This authorization applies to the following information. I have indicated below the information which I authorize for release:

[ ]  Medical Records [ ]  Dental Records [ ]  Mental Health Records [ ]  Alcohol and Abuse Records

[ ]  Drug Abuse Records [ ]  X-Ray Reports [ ]  Acquired Immunodeficiency Syndrome (AIDS, or test or

 infection with HIV Records)

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall be effective from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and shall remain in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If not completed, authorization will only be valid for 90 days from date of signature.

My health information will be used for the following purposes only\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I may inspect or obtain a copy of the health information that I am asked to use or disclose.

Copy requested and received: Yes [ ]  No [ ]  Initials \_\_\_\_\_\_\_\_\_\_\_

The requestor of my information may not condition treatment, payment, or health care operations on a signed authorization unless

* The authorization is for the provision of research-related treatment.
* To enable the requestor to determine its obligation to pay a claim.
* The purpose of the authorization is to permit the creation of information for the specific purpose of disclosure to a third party.

I may refuse to sign the authorization or I may revoke it at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. [ ]  I wish to revoke this authorization.

I have a right to receive a copy of this authorization

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by other than patient, indicate your legal relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you have authorized the disclosure of your health information to someone not legally required to keep it confidential, it may be redisclosed and may not be protected. California law prohibits the requestor from making further disclosure unless they receive another authorization from you or unless such disclosure is permitted by law.*