Disclosure of Mental Health Treatment Information

I, ______________________________, whose Date of Birth is _________, authorize *Elazar Bloom Counseling and Consulting, PLLC* to disclose to and/or obtain from:
the following information:

_____ Psychotherapy Notes

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to R. Elazar Bloom, LMFT at eb@elazarbloom.com. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

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 no longer be protected by the HIPAA privacy regulations, unless a state law applies that is stricter than HIPAA and provides additional privacy protections.

Signature of Client(s) ____________________________ Date _____________