Agoura Hills Counseling
Danielle Ciccone, Licensed Professional Clinical Counselor #4677
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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this document, I, ____________________ (hereinafter "Client") hereby authorize Danielle Ciccone, Licensed Professional Clinical Counselor #4677 (hereinafter "Provider") to disclose psychotherapy treatment information and records obtained in the course of psychotherapy treatment of Client to:

Name of Person/Agency: ______________________

Relationship to Client: ______________________

Phone: ______________________ Fax: ______________________

Email: ______________________

Address: ____

I understand that:

- I have a right to receive a copy of this authorization.
- I have the right to refuse to sign this form.
- Provider shall not condition treatment upon my signing this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.
- I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it.
- Such revocation, to be effective, must be in writing and received by

Provider at: 30101 Agoura Court, Suite 204, Agoura Hills, CA 91301.

This disclosure of information and records authorized by Client is required for the following **purpose:**

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Such disclosure shall be limited to the following specific **types of information and/or records:**

- ☐ Presence in treatment
- ☐ Progress in treatment
- ☐ Mental health diagnosis
- ☐ Mental health assessments
- ☐ Treatment plan
- ☐ Medical history/current status
- ☐ Discharge summary
- ☐ Aftercare recommendations
- ☐ Other: ______________________

This authorization is effective until the end date of: __________________

Client (Print Name): ______________________

Client (Signature): ______________________

Date: ______________________