

Lynn Ianni, PhD, MFT

California License #MFC21521
2829 Bottlebrush Drive - Los Angeles CA 90077
310-470-0234
drlynnianni@gmail.com

Authorization for Release of Information

I, _____, hereby authorize Dr. Lynn Ianni, PhD, MFT and
Client Name

_____, at _____ to exchange information.
Name Organization & Contact Info

The type of information to be disclosed:

- | | |
|---------------------------|--|
| Evaluations _____ | Medical/Hospital Records _____ |
| Diagnosis _____ | Psychological/Medical Test Results _____ |
| Treatment Plan _____ | Mental Health Record Summary _____ |
| Course of Treatment _____ | Psychotherapy Notes _____ |
| Other _____ | |

The purpose of such disclosure:

- | | |
|----------------------------|----------------------------------|
| Ongoing Treatment _____ | Medical Care _____ |
| Consultation _____ | Evaluation _____ |
| Transfer _____ | Legal issues _____ |
| Coordination of Care _____ | Health Benefit Utilization _____ |
| Other _____ | |

Exceptions: _____

The designated information about me () may () may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Dr. Ianni and the above designated person () may () may not discuss by telephone the content of the information released.

This consent is in effect until _____. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already take place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed psychotherapists, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Date

Signature of Client or Personal Representative

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

This authorization to disclose private health information is for the release of psychotherapy notes or purposes other than my treatment, payment or the related operations of the practice, and I understand that my authorization, or refusal, will not affect my ability to get treatment or payment. However, the Practitioner can condition those things (1) if the my treatment is related to research, or (2) if my treatment is being provided to me solely for the purpose of creating protected health information for disclosure to a third party. By my signature below, I acknowledge a receipt of this disclosure.

Date: _____

Signature of Client or Personal Representative