Kim Roser-Kedward, LCSW (LCS 22405)

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Authorization for Use/Disclosure of Confidential Information

By completing this form you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Patient Name: _____Date of Birth: _____

My therapist, Kim Roser-Kedward, LCSW, is authorized to (*check all that apply*):

- ☐ Release or disclose records and/or information to:
- ☐ Obtain or use records and/or information from:
- ☐ Mutually discuss and exchange records and/or information with:

_____

(Name of Person or Organization)

Specific Information to be Released/Obtained (Please select only one):

- ☐ All health/mental health information including diagnosis and treatment received.
- ☐ Only the following records or type of information:_____

Please specify if any information is to be excluded:_____

_____

This disclosure of information authorized by Patient is required for the following purpose:

_____

This authorization shall become effective immediately and expire in one (1) year.
A photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to Kim Roser-Kedward, LCSW. Your revocation will be effective when your therapist receives it. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditional on your providing or refusing to provide this Authorization.

_____ _____

Patient Signature Date

To Revoke Authorization Only:

Authorization Revoked: _____ _____

Date Signature of Patient