CRAIG TUCKER LCSW

▪ LCS 20312 ▪ 333 East Stuart Ave., Suite F, Redlands, CA 92374▪ Phone (909) 389-2414 ▪ Fax (909) 353-4982 ▪

Authorization for Use or Disclosure of Personal and Health Information

Explanation: This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

NAME OF CLIENT:_____ **DATE OF BIRTH**: _____
INSURANCE ID NUMBER: _____

☐ I refuse to authorize communication with: _____
(Name of Healthcare Practitioner)

Client Signature: _____
Print: _____ Date: _____

☐ I authorize Craig Tucker, LCSW to communicate with _____
Name of Health Care Practitioner/Collateral Contact

Address: _____
Phone Number: _____ FAX _____

This authorization is limited to exchanging the following medical records and types of information:
☐ Social History ☐ Medical History ☐ Psychiatric History ☐ Other:

_____

_____

_____

USE: My personal and health information is authorized to be released only for the following purposes:
☐ Assessment ☐ Diagnosis ☐ Other:

_____

_____

_____

DURATION:
This authorization shall become effective immediately and shall remain in effect until: _____

Please initial each statement to verify understanding:

_____ **CHANGES**: I understand that any requests to revise or cancel this authorization must be in writing.
_____ **RESTRICTIONS**: I understand that the requester may not further use or disclose the private and health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I also understand that treatment cannot be conditioned based upon signing this authorization.
_____ **COPIES**: I further understand that I will have copy of this request in my message box at my account at www.craigtuckerlcsw.com upon saving this request.

SIGNATURES
☐ Client ☐ Parent/Guardian:

_____
Print: _____
Date/Time: _____

Witness:

_____
Print: _____
Date/Time: _____