Diane Gleim
Licensed Marriage and Family Therapist
AASECT Certified Sex Therapist & Supervisor
IAPST Certified Psychosexual Therapist™ & Supervisor
LIC# MFC44429

Authorization to Disclose Confidential and Protected Health Information

I hereby authorize Diane Gleim, MFT to disclose the following mental health treatment information:

___Evaluations/Assessments
___Drug/Alcohol Information
___Clinical Test Results
___Psychotherapy Notes
___Medication Evaluations
___HIV Status
___Dates of Treatment
___Entire File

TO:

Name: _____

Address: _____

Phone Number: _____ Fax: _____

The disclosure of information is requested for the purpose of: _____

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Diane Gleim, MFT has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Diane Gleim, MFT to be effective. I understand that Diane Gleim, MFT cannot condition treatment upon me signing this authorization. I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

This authorization will remain in effect for 1 year unless otherwise stipulated below:

Print Name:_____ Signature: _____

Print Name:_____ Signature:_____

Effective Date:_____ Expiration Date:_____

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