Clinical and Forensic Psychologist PSY 17545
(949) 235-4874
docstacey@yahoo.com

Laguna Hills Office:
23421 South Pointe Drive, Suite 130
Laguna Hills, CA 92653

Mailing Address:
26895 Aliso Creek Road, Suite B, #627
Aliso Viejo, CA 92656

AUTHORIZATION FOR USE OR DISCLOSURE OF MENTAL HEALTH INFORMATION

Completion of this document authorizes the discussion, gathering, or disclosure and use of mental health information about your child and his/her treatment. Failure to provide all information requested may invalidate this authorization.

Use and Release of Mental Health Information

I affirm that I am a legal adult 18 years of age or older:

____
(Name)

I hereby authorize: **Stacey D. Berardino, Ph.D.**

To ____ discuss, ____gather, or ____release information about: ______________________
(Name)

To release to: (Psychiatrist, Medical Doctor, etc.):

____
(Name/Profession)

____
(Address)

____
(Address)

____
(Phone Number)

The following information:

A. ___ Any and all mental health information pertaining to any history, mental or physical condition and treatment received (excluding treatment notes);

B. ___ Only the following types of health information including any specific dates;

C. __ I specifically authorize release of the following information

___ Mental Health treatment information

___ Dates of Treatment

___ Substance Abuse Information

___ Other (Explain Below):

____

____

____

PURPOSE

Purpose of requested use or disclosure: ___ Patient Request ___ Other:

____

____

EXPIRATION

This authorization expires on: ____________________
(Date)

MY RIGHTS

-I may refuse to sign this authorization/consent form.
-I may revoke this authorization at any time, but I must do so in writing and submit it to the office.
-My revocation will take effect upon receipt, except to the extent those others have acted in reliance upon this authorization.
-I have a right to receive a copy of this authorization.
-Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California Law and may no longer be protected by federal confidentiality law (HIPAA). However, California Law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

____
(Name)

____________________________________ ________________
(Signature) (Date)

____________________________________ ________________
(Witness) (Date)

D R. S T A C E Y
BERARDINO
Ph.D. Clinical and Forensic Psychologist

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AUTHORIZATION FOR USE OR DISCLOSURE OF MENTAL HEALTH INFORMATION (FOR MINOR)

Completion of this document authorizes the discussion, gathering, or disclosure and use of mental health information about your child and his/her treatment. Failure to provide all information requested may invalidate this authorization.

Use and Release of Mental Health Information

I affirm that I am the parent or legal guardian of: ______________________________
(Minor's name)

I hereby authorize: **Stacey D. Berardino, Ph.D.**

To ____ discuss, ____gather, or ____release information about: ____________________
(Minor's name)

To release to: (School Institution/Teacher/Psychiatrist/Medical Doctor, etc.):

____
(Name/Profession)

____
(Address)

____
(Address)

____
(Phone Number)

The following information:

A. ___ Any and all mental health information pertaining to any history, mental or physical condition and treatment received (excluding treatment notes);

B. ___ Only the following types of health information including any specific dates;

C. __ I specifically authorize release of the following information

___ Mental Health treatment information

___ Dates of Treatment

___ Substance Abuse Information
___ Other (Explain Below):

____

____

____

PURPOSE

Purpose of requested use or disclosure: ___ Patient Request ___ Other:

____

____

EXPIRATION

This authorization expires on: ____________________
(Date)

MY RIGHTS

-I may refuse to sign this authorization/consent form.
-I may revoke this authorization at any time, but I must do so in writing and submit it to the office.
-My revocation will take effect upon receipt, except to the extent those others have acted in reliance upon this authorization.
-I have a right to receive a copy of this authorization.
-Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California Law and may no longer be protected by federal confidentiality law (HIPAA). However, California Law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

____
(Name of Parent, Guardian or Legal Representative)

______________________________ ______________
(Signature) (Date)

______________________________ ______________
(Minor's Name/Signature- Optional) (Date)

______________________________ ______________
(Witness) (Date)