Angela Copeland Psy.D.

Angela Copeland, Psy.D. PSY22974 3525 4th Avenue San Diego, CA 92103

Authorization for Use or Disclosure of Protected Health Information

Name of Patient:_____
Date of Birth:_____ SS#_____ MRN#_____
Daytime Phone#_____ Evening Phone #_____
Address:_____
City:_____ State:_____ Zip Code:_____

I hereby authorize Dr. Angela Copeland to obtain from or disclose my Protected Health Information to:

Name:_____
Daytime Phone#_____ Fax#_____
Address:_____
City:_____ State:_____

Information to be disclosed:
_____
_____
_____

Purpose of Disclosure:
_____
_____
_____

1 The undersigned agrees that this authorization will expire 2 years from today's date. A photocopy of this form will be considered as valid as the original.
2 The undersigned agrees that they may revoke this authorization at any time by notifying Dr. Angela Copeland, in writing and this authorization will cease to be effective on the date notified to the extent action has already been taken in reliance upon it.
3 The undersigned agrees that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specifically protected information.
4 The undersigned agrees to disclose all mental health records under the Laterman-Petris-Short Act, chemical dependency and/or alcohol treatment records. Information about their health that may relate to any disorder of the immune system including but not limited to, HIV, and AIDS results/treatment records, and Communicable Diseases.
5 The undersign's healthcare and payment for health care will not be affected if they do not sign this form.
6 The undersigned understands that their refusal to sign this authorization will not jeopardize their right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
7 The confidentiality of this record shalt not be transmitted to anyone without written consent or authorization.

Signed:_____ Date:_____

Print Name:_____

Witness:_____ Date:_____