Trishka L. Lampkin
Licensed Marriage & Family Therapist

Authorization for Use or Disclosure of Protected Health Information

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Phone: _____

Recipient Information

I, [printed name] _____ , request that my protected health information (PHI) from [healthcare provider] _____ be disclosed to:

Trishka Lampkin, LMFT
55 Springstowne Center 282
Vallejo, CA 94591
tlampkinmft2022@gmail.com
925-592-7155

Information to be Used or Disclosed

I authorize the following PHI to be released from my medical record(s):

☐ Entire Record
☐ Treatment Progress
☐ Diagnosis
☐ Test Results
☐ Treatment Plan or Goals
☐ Prognosis
☐ Other (specify): _____

Covering the period of healthcare from: _____ to _____

Disclosure Format

☐ Paper/Hard Copy (via U.S. Mail)

☐ Electronic (via E-Mail)

Purpose for Disclosure

☐ Further mental health care

☐ At the request of the individual

☐ Other (specify): _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees as authorized by state/federal law.
- I have the right to **REVOKE** this authorization at any time. Revocation must be made in writing and presented or mailed to:

  Trishka Lampkin, 55 Springstowne Center #282, Vallejo, CA 94591

- Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **EXPIRE** on the following date/event/condition:

  _____

  If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from the date signed.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure.
- I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the original.

Printed Name: _____

Signature of Patient or Authorized Representative: _____

Relationship to Patient (if applicable): _____

Date: _____