

**Dr. Heather Martarella**  
Licensed Clinical Psychologist  
PSY21758  
(925) 465-1008 www.drmartarella.com

**HIPAA Release of Information Authorization**

I, \_\_\_\_\_, whose date of birth is \_\_\_\_\_,  
authorize Dr. Heather Martarella to disclose to and/or obtain from

\_\_\_\_\_

the following information:

**Description of Information to be Disclosed**

(Client should initial each item to be disclosed)

<input type="checkbox"/> All Psychological Information	<input type="checkbox"/> Testing Information
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Presence/Participation in Treatment
<input type="checkbox"/> Other _____	

**Purpose**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: \_\_\_\_\_

\_\_\_\_\_

**Revocation**

I understand that I have a right to revoke this authorization at any time by sending written notification to Dr. Martarella at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration**

Unless revoked, this authorization expires one year from the date signed, or as otherwise indicated: \_\_\_\_\_

**Conditions**

I further understand that Dr. Martarella will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

\_\_\_\_\_

**Form of Disclosure**

Unless you have specifically requested in writing that the disclosure be made in a certain format, Dr. Martarella reserves the right to disclose information as permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Re-disclosure**

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: \_\_\_\_\_

I will be given a copy of this authorization.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian (if client is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_ Check here if client refuses to sign authorization

\_\_\_\_\_  
Heather Martarella, Psy.D.  
Licensed Clinical Psychologist  
CA License #PSY21758

\_\_\_\_\_  
Date