ELISA A. GOTTHEIL PH.D. PSY#22753
info@pathylog.com – *805-308-4568*

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDSrelated Information

Patient Name	Date of Birth	Phone Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to

☐ ALCOHOL and DRUG TREATMENT,

☐ MENTAL HEALTH TREATMENT, and

CONFIDENTIAL HIV/AIDSRELATED INFORMATION. This provider is mandated to release HIV/AIDS information to Public Health Department in the County of Santa Barbara, only.

2. With some exceptions, health information once disclosed may NOT be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDSrelated, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5, except to the extent that action has already been taken based on this authorization. This authorization will be valid between the signature date and one year after the signature date.

4. Signing this authorization is voluntary. I may not be denied treatment if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing this Information:

ELISA A. GOTTHEIL, LICENSED PSYCHOLOGIST
BUSINESS OFFICE ADDRESS
351 Paseo Nuevo, 2nd floor, SANTA BARBARA, CA93101

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. All items on this form have been completed; I have been asked what question I may have about this form, and if I did, my questions have been answered.

9. I have been offered a copy of this form and I accepted it/rejected it.

10. Release of the information requested on this form precludes re-disclosure of information to subsequent parties.

SIGNATURE OF PATIENT (OR REPRESENTATIVE AUTHORIZED BY LAW) DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

DATE

ELISA A. GOTTHEIL, PhD, Clinical Psychologist