Narrative Initiatives San Diego (NISD)
Counseling, Training and Research Center

Authorization for Release of Medical and Mental Health Information

***Explanation*:**
This authorization to receive or release mental health information is being requested of you, in compliance with the terms of the Confidentiality of Medical Information Act of 1981, section 56 of the California Civil code and current HIPPA guidelines.

Client Name:_____
Address:_____
Phone: _____Birthdate: _____

Authorization:
I, (Client Name) _____ hereby authorize:
Provider Name: _____
Organization: Narrative Initiatives San Diego (NISD)
Address: 3636 Fifth Avenue, 2nd Floor, San Diego, CA 92103
Phone: 619-786-7184
Email: info@nisdcounseling.org

To request written documents or discuss information about my medical and mental health consultations with:
Provider Name: _____
Organization: _____
Address: _____
Phone: _____Fax_____
Email: _____

I understand that I have the right to receive a copy of this authorization.
I understand that I may revoke the authorization at any time by notifying the provider in writing. The revocation will be effective on the date of its writing and will not be retroactive.

_____
Signature of Client Date