

Client or Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, the undersigned, hereby authorize:

- |   |   |
|---|---|
| <p>1. _____<br/>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> | <p>3. _____<br/>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> |
| <p>2. _____<br/>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> | <p>4. _____<br/>Name</p> <p>_____</p> <p>Address</p> <p>_____</p> |

to disclose records made in the course of my evaluation and/or diagnosis and treatment, to include the health history, medical, psychiatric, alcohol and drug abuse records, to the **California Board of Psychology and its representatives, including, but not limit to, investigators and legal staff, upon their request.** This disclosure of records authorized herein is required for official use including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the California Board of Psychology completes its investigation and proceedings arising out of the investigations.

I further agree that the Board and its representatives may release any and all of my records and treatment information to the Board of Behavioral Sciences and/or any other government agency which requests such information as part of an investigation into other possible violations of the laws of California.

**A copy of this authorization shall be as valid as the original.** I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Board of Psychology, 1625 N. Market Blvd., N-215, Sacramento, CA 95834. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Or Legal Representative \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

NOTE: Failure by a psychologist to provide the requested records within 15 days, or a health care facility in 30 days, of receipt of this request and authorization may constitute a violation of section 2969, of the Business and Professions Code. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.

### **Collection and Use of Personal Information**

The Department of Consumer Affairs and the California Board of Psychology collect the information requested on this form as authorized by Business and Professions Code sections 325 and 326 and the Information Practices Act.

### **Access to Your Information**

You may review the records maintained by the California Board of Psychology that contain your personal information, as permitted by the Information Practices Act. See contact information below.

### **Possible Disclosure of Personal Information**

We make every effort to protect the personal information you provide us. However, we may need to share the information you give us with other government agencies. This may include sharing any personal information you gave us.

The information you provide may also be disclosed in the following circumstances:

- In response to a Public Records Act request, as allowed by the Information Practices Act;
- To another government agency as required by State or Federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

### **Contact Information**

For questions about this notice or access to your records, you may contact the California Board of Psychology, 1625 North Market Boulevard, Suite N-215, Sacramento, CA 95834; by phone at (866) 503-3221; or by e-mail at [bopmail@dca.ca.gov](mailto:bopmail@dca.ca.gov). For questions about the Department's Privacy Policy, you may contact the Department of Consumer Affairs at 1625 North Market Boulevard, Sacramento, CA 95834; by phone at (800) 952-5210; or by e-mail at [dca@dca.ca.gov](mailto:dca@dca.ca.gov).