Robert B. Bannister, M.A., L.M.F.T.
LMFT27664
Psychotherapy for couples, families and individuals · Marriage & Family Therapist

AUTHORIZATION TO USE OR RELEASE PROTECTED HEALTH INFORMATION REGARDING MEDICAL, PSYCHIATRIC AND SUBSTANCE ABUSE RECORDS.

I hereby authorize: Robert Bannister, MA, LMFT
621 Chapala Street, Suite C
Santa Barbara, CA 93101
Office: 805-705-3987
FAX: 866-294-0916

To receive and release health information and records obtained during the course of treatment of:

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City/State/Zip _____ SS#: XXX-XX-____

The information is to be used or disclosed to/from the following person/organization.

Clinician/Entity: _____

Address: _____

Phone#: _____ Fax# _____

This release is at the request of: (specify) _____

Specify which records are to be released (Required).

_____

_____

The purpose of the disclosure is: _____

_____

I hereby release Robert Bannister, MA, LMFT from all legal responsibilities or liability that may arise from the use or disclosure of medical information in reliance on this authorization.

1. **Expiration**: I understand that unless I revoke the authorization, in written notice to Robert Bannister sooner, this authorization automatically expires 180 days from the date this authorization executed on: _____
2. **Re-disclosure**: I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or re-disclosed as the law permits by the receiving party.
3. **Refusal to sign**: I understand that I may refuse to sign this authorization and that Robert Bannister, MA, LMFT will not condition treatment, payment or eligibility for benefits on whether I sign this document.
4. **Certification**: I certify that I am the patient. ☐
   I am the patient's authorized representative and that the proof I provided is accurate. My relationship to the patient is:
   _____
5. **Revocation**: I have the right to revoke this release (in writing and delivered to Robert Bannister). I understand that there is no remedy for information already disclosed under this authorization.
6. **Minors**: I understand that minors must sign the authorization in addition to their parent/guardian.
7. **Copy**: I understand that I will receive a copy of this authorization if I so indicate here: _____ _____
   Yes (Initial choice) No
8. I agree that a copy or fax of this authorization is as effective as the original.
9. I understand that I will be billed $15.00 plus 25¢ per page for copies of records for my personal use or for paper copies mailed to authorized receiving parties.

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal statutes, rules and regulations. (California Administrative Code, Title 22, California Welfare and Institutions Code 5328, and Title 42 of the Code of Federal Regulations and HIPAA.)

_____	_____
Patient	Date
_____	_____
Parent/Guardian	Date

_____	_____	_____
Witness	Print Last Name	Date

Revised 1/9/2016

Robert Bannister, MA, LMFT

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