Form # 5 **Nita Prasad, LMFT 43500**

(650) 564-7370

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____(DOB: __ /___/____) authorize _____

☐ to release information to: ☐ to receive information from:

_____

(name of individual , title, agency, or school)

_____

(address) (city, state, zip) (area code & telephone)

regarding _____

I authorize the following information to be released:

☐ Any and all information necessary ☐ Diagnosis ☐ Patient records

☐ Treatment plan ☐ Prognosis ☐ Clinical test results ☐ Dates of treatment

☐ Summary of treatment ☐ Other:_____

for the purpose of (and limited to):

☐ Assessment and treatment ☐ Professional consultation ☐ Reimbursement

I understand that I am entitled to a copy of this form. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I understand that such revocation must be in writing and received by Provider to be effective. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information. This release shall be valid for one (1) year from the date below.

I have read and understand all of the terms and conditions above.

_____ _____

Signature /Date *(relationship to client)*

_____ _____

Signature /Date *(relationship to client)*

_____

Signature of Witness/Date

☐ copy to client ☐ client declined a copy