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Authorization to Release Protected Health Information

<p>By signing this document, I, _____, (hereinafter "Patient") hereby authorize Stephen Mardell, MFT, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of Patient, to:</p>	
<p><i>(Name and functions of the person or entity to whom disclosure is made)</i></p>	
<p>I understand that:</p> <ul style="list-style-type: none">• I have a right to receive a copy of this authorization• I have the right to refuse to sign this form• Provider shall not condition treatment upon my signing this authorization• 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• I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it• Such revocation, to be effective, must be in writing and received by Provider at: <p>5014 Chesebro Road Agoura Hills, CA 91301</p>	<p>This disclosure of information and records authorized by Patient is required for the following purpose:</p> <ul style="list-style-type: none">• For Coordination of Treatment• Other: _____ <p>Such disclosure shall be limited to the following specific types of information:</p> <ul style="list-style-type: none">• Diagnosis• Results of psychological/vocational testing• Summary of psychosocial/psychiatric history/treatment• Medical and neurological information• Educational assessment and behavioral reports• Other: _____

This authorization is effective for one year from the date signed, or until:

End Date _____

Patient (Print) _____ Signature _____ Date _____

Parent/Legal Guardian (Print) _____ Signature _____ Date _____

