Mark Goldstein, Ph.D

CLINICAL PSYCHOLOGY

psychotherapy • assessment • consultation

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AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize **Mark Goldstein, Ph.D.** to disclose mental health treatment information and records obtained in the course of my psychotherapy Treatment to:

I understand that I have a right to receive a copy of this authorization. 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. And, I also understand that such revocation must be in writing and received by **Mark Goldstein, Ph.D.** to be effective.

This disclosure of information and records authorized is required for the following purpose:

_____

Such disclosure (if no limitations, please write "none" in the space below) shall be limited to the following specific types of information:

_____

_____

I understand that I have the right to refuse to sign this form. 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 authorization shall remain valid until: _____

_____ _____

Patient(Parent/Guardian) name ***signature*** Witness

_____ _____

Patient (Parent/Guardian) ***please print*** Date