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Authorization to Release Records

I,(Patient)_____, hereby authorize (Communicant)_____ and Marilyn K. Viera, LCSW to exchange my health records and information obtained during the course of treatment.

The disclosure of such records authorized herein is required for the following purpose(s):

_____

_____

Such disclosure shall be limited to the following use of information:

Diagnosis

Medications

Treatment

_____

Such disclosure shall be limited to the following type of information:

_____

_____

This consent shall expire on:_____

The patient can request a copy of this authorization. The patient has a right to refuse to sign this form. The patient understands that information that is used or disclosed according to this authorization may be subject to re-disclosure by the recipient. The provider will not make providing treatment a condition of signing this Authorization. The patient is entitled to receive a copy of this form. For revocation of this form, the Patient must provide a written request to the clinician named above. California law may provide additional protection regarding the possible re-disclosure stated above.

Date_____Signature of Client _____