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AUTHORIZATION TO RELEASE INFORMATION ("PHI")

I hereby authorize Hannah Singer, Psy.D. (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy to the following requesting parties:

NAME ____

ADDRESS ____

I understand the following in regards to my rights: I have the right to receive a copy of this authorization. I have the right to revoke this authorization at any time unless the provider has taken action in reliance upon it. Any cancellation, revocation, or modification of this authorization must be in writing and received by the provider at 15720 Ventura Blvd. Suite 204, Encino, CA 91436. 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 redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

INFORMATION TO BE RELEASED OR EXCHANGED

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PURPOSE OF RELEASE ____

AUTHORIZATION SHALL REMAIN VALID UNTIL ______________________________

PATIENT NAME_____________________________________ DATE _______________

PATIENT SIGNATURE ____