Authorization to Request and/or Release Information

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Kym Lundberg, MFTi to ***exchange*** information with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person or Organization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Code

The information to be disclosed includes:

Medical Records\_\_\_\_\_ Mental Health Information \_\_\_\_ Drug & Alcohol Information\_\_\_\_

Psychiatric/Psychological Evaluations\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ All above Clinical Information \_\_\_\_

The purpose for the release is: Continuity of Care\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_

Dates include: All dates of treatment \_\_\_\_\_ *or*  From \_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information released may include a diagnosis or reference to the following conditions: behavioral health services/psychiatric care; AIDS or HIV; or drug or alcohol abuse. If the information to be released pertains to the diagnosis and treatment of alcoholism and/or drug abuse, I understand that Federal Law 42, CFR Part 2 protects the confidentiality of that information. I understand that treatment, payment, enrollment and eligibility for benefits may not be conditioned on signing this authorization.

I hereby understand that the information disclosed pursuant to this Authorization might be rediclosed by the recipient and may no longer be protect by the Federal Privacy Regulation 45 CFR Part 164. I release the provider from all liability for disclosing the requested information.

I certify that this Authorization is voluntary and I understand that I may refuse to sign this Authorization. I may revoke this consent at any time by providing written notice, except to the extent that the provider has already taken action on this request.

The Authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (or one year from the below date).

Signature of Client or Legal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Legal Representative Relationship to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature

Kym Lundberg, MA, Registered MFT Intern (IMF95251), Supervised by Rebekah Balboni, LCSW (License # 24270)

(510) 556-8368 2233 Santa Clara Ave, #1, Alameda, CA 94501 kymlundbergMA@gmail.com