Stephen Mardell, MFT
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CA License MFC 33517

Authorization to Release Protected Health Information

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:

*(Name and functions of the person or entity **to whom** disclosure is made)*

I understand that:

- 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:

  5014 Chesebro Road
  Agoura Hills, CA 91301

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

- For Coordination of Treatment
- Other: _________________________

Such disclosure shall be limited to the following specific **types of information**:

- 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 _________