Deborah Essex, MFT
Individual, Family & Child Counseling
2931 Shattuck Avenue, Suite 101E
Berkeley, CA 94705
510.548-8980
e-mail: therapyde@gmail.com

AUTHORIZATION TO RELEASE INFORMATION

I, **(name of patient, or legal gaurdian)** _____, hereby authorize **Deborah Essex, MFT** 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:

_____
_____

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 Provider at **2931 Shattuck Avenue, Suite 101E, Berkeley, CA 94705** to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose: _____
The specific uses and limitations of the types of medical information to be discussed are as follows **(be as specific as you choose to)** :

_____
_____

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

_____
_____

Therapist shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

Patient understands 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's signature: _____ Date:_____