Authorization to Release Information

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Providing Support for Life's Transitions

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Patient's Name: _____

Date of Birth: _____

Consistent with California and Federal Law, I authorize the disclosure and/or use of my Protected Health Information (PHI) as described below:

____Melissa Staehle, Ph.D. is authorized to release my PHI to:

Name: _____
Address:_____
Phone: _____
Fax: _____

____Person/Organization below is authorized to release PHI to Melissa Staehle, Ph.D.

Name: _____
Address: _____
Phone: _____
Fax: _____

Purpose for PHI Disclosure:

____Evaluation/Diagnosis
____Treatment/Treatment Planning
____Consultation
____Other: _____

This authorization shall remain valid until: _____

I understand that I have a right to receive a copy of this authorization. This authorization will be placed in my file. I understand that any modification or cancellation of this authorization must be in writing to be effective. I have read and understand this form and authorized the release of my PHI as noted above:

_____
Patient Signature Date