

Authorization for Release of Information

I hereby authorize Lisa Tang, Ph.D. (91 W Neal St., Pleasanton, CA 94566, phone: 925-963-8835, fax: 855-834-5419) to (check all that apply):

Exchange with Release to Obtain from the parties indicated below

information from records about _____ / ____ / ____ for the
following purposes: Client Name Date of Birth

- Coordination of care Treatment planning Inform psychological / educational assessment
 Further mental health evaluation, treatment, or care Other (specify) _____

I hereby authorize Dr. Tang to exchange / release / obtain information:

verbally only In written form only both verbally and in writing

Description of health information to be released / exchanged / obtained:

- Treatment / Progress Summary Psychological Assessment Report Medical History
 Intake and Discharge Summaries Educational Records Treatment Session Notes
 Other (specify) _____

Person receiving / communicating the information:

Name / Organization: _____

Phone: _____ Fax: _____

Address: _____

I understand that this authorization is voluntary on my part. I understand that I may revoke this authorization at any time by notifying Dr. Tang in writing, but if I do, it will not have any effect on any disclosures already made before receipt of the revocation.

I understand that this authorization will expire:

- On ____ / ____ / ____ or one year from the date of the signature below. By California state law, this Authorization terminates 60 days after the termination of treatment / completion of psychological evaluation.

I understand that my health information is protected by the Federal Rules for Privacy of individually Identifiable Health Information and state laws. I also understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

Signature of Client / Legal Guardian

Date

Printed Name of Legal Guardian

Relation to Client (if not self)