Stephen A Friedman, MA, MFT
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CAL LIC # MFC 25481

AUTHORIZATION FOR RELEASE OF INFORMATION

This form when completed and signed by you, authorizes Stephen A Friedman, MA, MFT to release protected information from your clinical record to the person you designate.

I, _____, hereby authorize and give my written permission to have Stephen A Friedman, MA, MFT, release and exchange the following medical information:

Mental Health Diagnosis_____
Medication Management Information_____
Other Mental Health Treatment Information (incl. Medical/Social History_____
Other information specified here_____
Substance Abuse Information_____

Such information is for the purpose of evaluation, treatment, and notation of progress. Information will be released on an as needed basis. This information should only be released to: (Provide name, phone number, and address of person to whom the information is to be released)

_____

This authorization shall remain in effect until the following date (____/____/____) or until (fill in an event that relates to the purpose of this authorization).

_____

I understand that I have the right to revoke or modify this authorization, in writing, at any time by sending written notification of that revocation or modification to the office of **Stephen A Friedman, MA, MFT**. However, my revocation or modification will not be effective until **Stephen A Friedman, MA, MFT**, receives it. I understand that my records are protected by state and federal confidentiality laws and that, with specific exceptions under state law, information cannot be disclosed without my written consent. I understand that by my signature below, I have waived this right to confidentiality. I further understand that my marriage and family therapist generally may not condition psychological services upon my signing an authorization where the HIPAA Rule may no longer protect my information.

I hereby relieve and release **Stephen A Friedman, MA, MFT**, from any damages, claims and causes of action arising out of, or in connection with, any release of information.

_____
Client Name Printed   Date   Client Signature

_____
Parent/Guardian Name Printed   Date   Parent/Guardian Name Signature