

Authorization to Release Confidential Information

I, _____ Parent of _____
hereby authorize Julie Hussman, L.A., MFT
580 Broadway
Suite 208
Laguna Beach, CA 92651

to release confidential information obtained during the course of his
treatment to _____,
_____ of _____ .

This Authorization permits the release of the following information:
____ Diagnosis ____ Treatment Plan ____ Progress to Date
____ Prognosis ____ Clinical Test Results ____ Dates of Treatment
____ Any and All Information Necessary
____ Other (specify)

I authorize the release of the information described above for the following
purpose(s):

The specific uses and limitations on the types of information to be released
are as follows:

The specific uses and limitations on the use of the information by Recipient
are as follows:

I understand that I have a right to receive a copy of this Authorization, and
that any modification or revocation of this Authorization must be in writing.
The Authorization shall remain valid until: _____

By: _____ Date: _____
(Patient or Patient's Representative)

Address: _____

Phone No: _____