AUTHORIZATION FOR RELEASE OF INFORMATION

FROM-----Dr. Joan Browner

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal Law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this authorization.**

Patient's Name:

_____

Date of Birth: ____/____/___ Social Security Number: _____-_____-_____

This will authorize: Joan Browner, Ph.D.
16550 Ventura Blvd. Suite 210
Encino, CA 91436
T: (818) 386-8084
F: (818) 386-8096

To Release to: _____

_____

_____

RECORDS:

- ☐ Assessment
- ☐ Discharge Summary
- ☐ Treatment Plan
- ☐ Psychological Evaluation
- ☐ Other _____

Date of Service for Records: From _____Through _____

The information hereby released will be used for the following purpose:

_____

_____

I understand that these records are protected by the California Welfare and Institution Code Section 5328 and that additional consent must be obtained for any other transfer or disclosure of information.

This authorization shall become effective ___/___/_____ and may be revoked by the undersigned party at any time. My revocation must be in writing, signed by me or my representative and delivered to Dr. Browner-16550 Ventura Blvd. #210, Encino, CA 91436. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. If not earlier revoked, this consent shall terminate on _____/____/____.

Termination date should not exceed 90 days from effective date unless treatment plan justified ongoing communication with the above named agency. Under no circumstances should termination date exceed one year.

I understand I have a right to receive a copy of this authorization if I so request.

_____ _____

(Date) (Signature of Patient)

_____ _____

(Signature of Witness) (Signature of Parent/Guardian)

A photocopy of this form is as valid as the original document.

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TO-----Dr. Joan Browner

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Patient's Name:

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Date of Birth: ____/____/_____ Social Security Number: _____-_____-_____

This will authorize: _____

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To Release to: Joan Browner, Ph.D.
16550Ventura Blvd. Suite 210
Encino, CA 91436
T:(818) 386-8084
F:(818) 386-8096

RECORDS:

- ☐ Assessment
- ☐ Discharge Summary
- ☐ Treatment Plan
- ☐ Educational Records
- ☐ Physical Examination
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Other _____

Date of Service for Records: From _____ Through _____

The information hereby released will be used for the following purpose:

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