Susan Chakmakian, M.A., M.F.T.

Authorization to Release Confidential Information

I,_____("Patient")

hereby authorize **Susan Chakmakian, MA, MFT** ("Provider") to disclose mental health treatment information and records obtained in the course of my treatment to:

Name: _____("Recipient")

Address: _____

Phone: _____

This Authorization permits the release of the following information:

____ Diagnosis and Attendance record

____ Summary of Treatment

____ Complete Copy of my file

____ Other (specify) _____

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. I understand that I have the right to revoke this authorization at any time unless provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by provider to be effective.

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

_____

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 cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I understand that such revocation must be in writing. I understand that Provider cannot condition treatment upon me signing this authorization. I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

The Authorization shall remain valid until: _____/_____/_____ ("Expiration Date")

By: _____ Date: _____

(Patient or Patient's Representative)

620 North Brand Blvd., Suite 401
(818) 839-0390