AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested (by "blank" lines) must be provided for this Authorization to be valid.

I, _____ DOB: _____ hereby authorize:

(name and phone number of person or facility) _____

_____ to release any and all information in my case record, including diagnosis, treatment plan, and services received, to Beth Leedham, Ph.D. I also authorize Beth Leedham, Ph.D. to release any and all information from the evaluation/treatment of me to (name of person or facility only) _____. Such disclosure/exchange of information is for the purpose of clinical consultation, evaluation, treatment planning, and/or coordination of services.

This Authorization becomes effective on the date of my signature below and is subject to revocation at any time. A facsimile or photocopy of this Authorization is as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.

Name (Printed) _____ Date _____

Signature _____

To revoke authorization only:

Authorization revoked: _____ (date)

_____

Signature