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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize Dr. Louise Packard to disclose/exchange protected health information with:

_____

Address and phone number:_____

I authorize this release of information for the following purposes:

_____

The specific uses and limitations of my protected health information are as follows:

_____

I understand that Dr. Louise Packard Ph.D. cannot condition treatment upon my signing of this document. 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 may cancel or revoke this authorization at any time unless Dr. Packard has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Dr. Packard in order to be effective.

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.

This Authorization may remain valid until:_____
Authorization effective date

_____ _____ _____
Signature of client/legal guardian | Client/legal guardian name (print) | Date