Lia Roy, LMFT

Request and Authorization to Release Confidential Information

I, the undersigned, hereby request the release of confidential information and grant authorization for the release of confidential information regarding the following patient. Including personal, mental health, chemical dependency, or medical history, findings, opinions, diagnoses, services rendered, and prognoses:

☐ except for_____
☐ with no exceptions

Patient's Name Date of Birth

Social Security Number Approximate Date(s) of Treatment

☐ Release by
☐ Furnished to
☐ Both

Lia Roy, LMFT
22900 Ventura Blvd, Suite 260
Woodland Hills, California 91364
(818) 515-4576

☐ Released by_____
☐ Furnished to_____
☐ Both_____

Information requested is the following:

☐ Pertinent summary
☐ Medical history/exam results
☐ Psychiatric evaluation result
☐ Psychological test results
☐ Complete patient record
☐ Psychosocial history
☐ Consultation reports
☐ Diagnostic impressions
☐ Course of Treatment
☐ Progress/process notes
☐ Discharge summary
☐ Dates of service
☐ School or work performance
☐ Other (specify)_____

This information is for the purpose of:

☐ Evaluation
☐ Treatment planning
☐ Forensic Service
☐ Continuity of care
☐ Consultation
☐ Doctor's Lien
☐ Referral
☐ Insurance reimbursement
☐ Subpoena
☐ Other (specify)_____

This authorization shall be effective immediately. A photocopy of this authorization shall be considered as valid as the original. Information may be released orally, in writing, or by photocopy. Information disclosure may be in person, by telephone, mail, or facsimile.

I understand that I have no obligation to consent to release of information, that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, in which event information cannot and will not be released, unless otherwise required by law.

I understand the recipients of information and prohibited by law from making any further disclosure to parties unless expressly permitted by additional written consent or otherwise required by law.

I understand that I can revoke my consent in writing at any time in writing, except to the extent that action has already taken in reliance upon my consent. If not earlier expressly revoked, this authorization will remain in effect for one year from the date of signing below.

I agree to hold harmless those authorized above, and their agents, designees and representatives from any and all liability arising from the release of information to the person(s) agencies(s) designated above, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

I understand that I have a right to receive a copy of this authorization upon my request. A copy of this form has been requested and received. □ YES □NO
Initials_____

I, the undersigned, am □ the above client, □the parent or legal representative of the above-named minor client □the beneficiary or personal repetitive of the above-name client who is deceased.

I have read, understood and agreed to the above conditions. I have clarified any questions before signing. I hereby grant my consent.

Client,	Print Name	Therapist	Date
Parent, or Responsible Person Signature	Relationship, if other than client		