LAUREN FEINER, PSY.D.

LICENSED CLINICAL PSYCHOLOGIST
CA PSY 26049

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: _____
Last *First* *M.I.*

DOB: _____ *Phone Number:* _____

I hereby authorize Dr. Lauren Feiner, 7817 Herschel Ave Suite 202, La Jolla, California 92037, to:

□ Communicate with □ Release Treatment Summary to □ Release Clinical Record to

_____
Name of Person or Organization Receiving Information

_____
Mailing Address *City*

_____
State *Zip Code* *Phone Number*

Purpose: The specified recipient may use the health information authorized on this form solely for the following purpose(s):

_____

Expiration: This authorization becomes effective immediately and shall expire on (typically 1 year):

_____
Date

My Rights:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me, or unless the use or disclosure is specifically permitted by law.
- I reserve the right to withdraw or revoke this authorization, in writing, at any time, except to the extent that Dr. Feiner has already disclosed the information.
- I have a right to receive a copy of this authorization.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient