ROBERT PERL, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST

1903 BERKELEY WAY #1
BERKELEY, CALIFORNIA 94704

PSY 18500
510-595-4609

AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this document, I (name of patient) _____ (hereinafter "Patient") hereby authorize Robert Perl, Psy.D. (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of Provider's treatment of Patient, including, but not limited to, Provider's diagnosis of Patient, to:

_____
(name and functions of the person or entity to whom disclosure is made)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification 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. And, I also understand that such revocation must be in writing and received by Provider at 1903 Berkeley Way #1, Berkeley, California 94704 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

_____

The specific uses and limitations on the types of medical information to be discussed are as follows:

_____

Such disclosure shall be limited to the following specific types of information:

_____

Provider shall not condition treatment upon Patient signing this authorization. Patient has the right to refuse to sign this form. Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, although such information may be protected by applicable California law.

This authorization shall remain valid until: _____

Patient or Legal Guardian: _____ Date: _____