Authorization to Release Information

Patient: _____

Address: _____

This will authorize:

(NAME, ADDRESS)

_____

_____

_____

_____

AND Lisa S Knakal, M.A., LMFT INC
26322 Calabasas Rd., Suite # 104
Calabasas, California 91302
MFC 50974

to disclose mental health information:

I, _____, (hereinafter "Patient") hereby authorize Lisa S. Knakal, M.A., (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including; but not limited to, therapist's diagnosis.

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 23632 Calabasas Road, Suite # 106, Calabasas, California 91302, (818) 222-6340.

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

_____

_____

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to be):

_____

_____

_____

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 HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Patient Signature: _____Date: _____

Therapist Signature: _____Date: _____