14011 Ventura Blvd., Suite 203A
Sherman Oaks, CA 91423
213.479.8730

Authorization to Release Confidential Information

I, ____________________________, hereby authorize Dain Kloner, PsyD, LMFT, to release confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be released]

____.

This Authorization permits the exchange of the following information:

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Any and All Information Necessary

____ Other (specify) ____

I authorize the release of the information described above for the following purpose(s):

____

____

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

____

____

The specific uses and limitations on the use of the information by Recipient are as follows:

____

____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: _____________________

By: ____ Date: __________________
(Patient or Patient's Representative*)

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