AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Lindsey Brooks Ph.D. Licensed Psychologist – CA PSY 24418
415-737-5540 (Phone)
lindsey@drlindseytherapy.com
1300 25th Avenue Suite 100 San Francisco, CA 94122

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

Client's Name: _____

Last First M.I.

DOB: Phone Number:

I hereby authorize Dr. Lindsey Brooks, to:		
□ Communicate with	□Release/Obtain Treatment Summary to/from	□ Release/Obtain Clinical Record to/from
Name of Person or Organization Receiving Information		
Mailing Address		
Phone Number	*Fax Number*	*Email Address*

DISCLOSURE OF RECORDS SHALL BE LIMITED TO THE FOLLOWING:		
□ Treatment Summary	□ Progress Notes	□ Treatment Plan
Other **(specify):** _____		
THE DISCLOSURE OF RECORDS IS REQUIRED FOR THE FOLLOWING PURPOSE:		

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. Brooks has already disclosed the information.
I have a right to receive a copy of this authorization.

Expiration: This agreement is effective immediately and automatically expires in **1 year.**

Client's Printed Name Client's Signature Date